



POLICY II PROJECT: NETWORKING FOR POLICY CHANGE— WHAT WORKS

JUNE 2006



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ACKNOWLEDGMENTS

The POLICY Project would like to acknowledge the U.S. Agency for International Development (USAID) for supporting the role of civil society in policy development and for providing POLICY with the means and mechanism to promote such efforts. Over the course of the POLICY Project, reproductive health advocacy networks emerged as an effective means for building civil society capacity and improving public sector policy responses to family planning, reproductive health, maternal health, and HIV-related issues. This document is produced in recognition of the many accomplishments of advocacy networks around the world that have strengthened the policy environments in their countries and communities.

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EXECUTIVE SUMMARY

Policy change is influenced by several factors, including the issue, context, process, and actors. This paper presents case studies of networks in 11 countries assisted by the POLICY Project to demonstrate how reproductive health advocacy networks were influential actors that played a role in fostering significant policy changes over the past decade.

In 1995, with the launch of the POLICY Project, the U.S. Agency for International Development (USAID) sought to put the principles of meaningful participation and civil society engagement in family planning/reproductive health (FP/RH) policymaking—as articulated during the 1994 International Conference on Population and Development—into practice. The objective of POLICY was to create an enabling environment for the formulation and implementation of policies and plans that promote and sustain access to high-quality FP/RH, HIV, and maternal health services. USAID and POLICY recognized that civil society-led networks and coalitions could play a significant role in encouraging political commitment for FP/RH, facilitating broader stakeholder participation in policy processes, and ensuring improved quality of and equitable access to services. Reproductive health advocacy networks, therefore, became a critical mechanism for POLICY in its efforts to promote participation of civil society groups and other partners in the health policy arena.

Between September 1995 and June 2005, POLICY formed and/or strengthened over 100 networks and coalitions designed to advocate for improved FP/RH, adolescent reproductive health, maternal health, and HIV policies and programs. Networks were formed at national, regional, and district levels and involved a range of organizations, including NGOs, women’s and youth groups, people living with HIV, faith-based organizations, businesses, journalists, healthcare providers, human rights groups, public health researchers, and, in some cases, partnerships with government officials. Most of POLICY’s technical assistance to networks focused on policy analysis and advocacy training, provision of small grants to support network building and/or advocacy activities, and organizational capacity development. To guide its work with networks, POLICY produced *Networking for Policy Change: An Advocacy Training Manual* in 1999. The manual is a key training resource, available in major languages, and has been supplemented by topic-specific materials focusing on issues such as maternal health, contraceptive security, and adolescent reproductive health.

The 11 case studies feature networks in Ghana, Guatemala, India, Nepal, Peru, Philippines, Romania, Russian Federation, Uganda, Ukraine, and Turkey. For example, in 2004, Uganda’s Ministry of Health adopted the country’s first comprehensive National Adolescent Health Policy. This action came after a reproductive health network researched the need for youth-friendly services, highlighted barriers to program implementation due to the lack of a comprehensive policy, and advocated for approval of the policy among key decisionmakers. This is just one of the accomplishments explored in this paper.

Specific factors that fostered advocacy networks’ success include: commitment to a shared goal/mission; commitment to a unifying issue; implementation of a common strategy; technical and organizational capabilities; inclusiveness and representation; and public sector engagement. Country experiences indicate that many of these factors were interrelated, with organizational and technical competence underlying most of the factors. Overall, networks and coalitions, whether at the national or local level, can directly influence policy reform, but they must be unified, committed, and well organized, have requisite technical skills, and engage various groups. Once government champions and supportive groups are identified, networks must partner with these champions and groups to maximize effectiveness, and even foster sustainability. In several countries where the foregoing occurred, civil society-led networks have truly helped to reshape the FP/RH, HIV, and maternal health policy environments.

ABBREVIATIONS

ABLE	Advocates for Better Living
AG	Advisory Group
AGMM	Guatemala Women’s Physician Association
AGOG	Guatemalan Association of Gynecology and Obstetrics
AIDS	acquired immune deficiency syndrome
AIM	AIDS Impact Model
ANM	auxiliary nurse-midwife
ARH	adolescent reproductive health
CBO	community-based organization
CEDPA	Centre for Development and Population Activities
CEPREC	Center for the Prevention and Resolution of Conflicts in Health
CIES	Consortium of Economic and Social Research
CII	Contraceptive Independence Initiative
CONSTRASIDA	AIDS Law (Peru)
CPR	contraceptive prevalence rate
CS	contraceptive security
CSC	citizen surveillance committee
DA	District Assembly
DFID	Department for International Development
DOH	Department of Health
EmOC	emergency obstetric care
FGD	focus group discussion
FP	family planning
GOI	Government of India
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IDU	injecting drug user
IEC	information, education, and communication
IGSS	Institute for Social Security
KIDOG	Kadin İçin Destek Olusturma Grubu or NGO Advocacy Network for Women
MH	maternal health
MOH	Ministry of Health
NAC	National AIDS Council
NCASC	National Center for AIDS and STD Control
NGO	nongovernmental organization
NPC	National Population Council
NRHP	National Reproductive Health Plan (Ukraine) or Program (Guatemala)
PDG	Policy Development Group
PLHIV	person or people living with HIV
POPCOM	Population Commission
RCH	reproductive and child health
RH	reproductive health
RHAN	Reproductive Health Advocacy Network
RN	Recovering Nepal
RNPM	National Network for Promotion of Women
RPAC	Regional Population Advisory Committee
RTI	reproductive tract infection

SM	safe motherhood
STI	sexually transmitted infection
TFR	total fertility rate
TOT	training of trainers
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDCP	United Nations International Drug Control Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URHAN	Uganda Reproductive Health Advocacy Network
URHN	Ukrainian Reproductive Health Network
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
VSC	voluntary surgical sterilization
WHO	World Health Organization
WRA	White Ribbon Alliance
WRAI	White Ribbon Alliance–India

INTRODUCTION

Breakthroughs in reproductive health policymaking and reform have been taking place during the last 10 years in Africa, Asia, Eastern Europe, and Latin America. Many of these breakthroughs occurred because of the key role played by advocacy networks. For example, **Uganda**'s first comprehensive National Adolescent Health Policy was finally approved after a reproductive health advocacy network reviewed and supported the document. In **Ghana**, local policymakers endorsed the integration of family planning into local HIV programs after meeting with leaders of advocacy networks. In **Nepal**, proposals by the first-ever coalition of recovering injecting drug users (IDUs) were incorporated into the HIV/AIDS bill that is under deliberation. The White Ribbon Alliance-**India** was requested by the health ministry to lead in developing and implementing safe motherhood guidelines. In **Russia**, members of a federal reproductive health network campaigned and secured the approval of regional reproductive health policies and funding. In **Ukraine**, regions have adopted and funded the National Reproductive Health Plan and established youth centers resulting from advocacy efforts of the national reproductive health network. In 2003, in **Romania**, the 2000 policy approving free contraceptive provision to poor clients was revised to permit self-certification of poverty status after local coalition members presented data showing that the poor still could not access free family planning commodities. After decades of governments that were not supportive of reproductive health issues, coalitions in **Guatemala** led advocacy campaigns spanning several presidential administrations to ensure adoption, implementation, and funding of the national reproductive health program. In 1997, in **Peru**, following allegations of forced targets and sterilizations under the Fujimori regime, a national women's network set up citizen surveillance committees to monitor compliance with new reproductive health guidelines emphasizing client needs and rights.

The foregoing milestones have one thing in common: networks or coalitions advocating for policy and program changes in the areas of family planning/reproductive health (FP/RH), maternal health, and HIV. These networks, along with scores of other alliances, received some form of technical assistance from the USAID-funded POLICY Project. What specifically made networks succeed? What lessons and potential benefits do network-led initiatives provide for reproductive health policymaking and implementation, in particular, and for public policy, in general?

This paper attempts to answer these questions by focusing on a select group of networks and coalitions that advocated for FP/RH, maternal health, and HIV and, as a result, influenced policy actions in their countries. The paper starts with a brief background on civil society participation in reproductive health policymaking. An analytical framework is presented below, followed by a description of data sources and the methodology used. The paper then presents case studies of networks in 11 countries assisted by the POLICY Project. The case studies are analyzed to arrive at general observations and conclusions on key factors that helped reproductive health advocacy networks undertake successful advocacy campaigns. (For summary information on the case studies, please see pages 11–14.)

Background

Civil society participation in reproductive health policymaking rose to prominence when nongovernmental organizations (NGOs) advocated for improved client access to services in the 1994 International Conference on Population and Development (ICPD) Program of Action. Since then, civil society participation has been stressed in country and donor efforts. Indeed, broadened participation became a major pillar of the USAID-funded POLICY Project (referred to hereafter as POLICY). The objective of POLICY was to create an enabling environment for the development and implementation of

policies and plans that promote and sustain access to high-quality FP/RH, HIV, and maternal health services. Achieving this objective involved assisting government and non-government partners in developing nations in their efforts to increase political and popular support for FP/RH, improve planning and financing, ensure evidence-based policy decisions, and enhance local policy skills.

USAID and POLICY recognized that civil society-led networks and coalitions could play a significant role in building political commitment and public support for FP/RH and facilitating broader stakeholder involvement and participation in policy processes. Considering their potential wide reach, community power bases, and ties with organizations from other sectors, networks could help build public-private partnerships for FP/RH, HIV, and maternal health services more effectively compared to efforts of one or a few organizations. After more than 10 years of POLICY assistance (POLICY I, 1995–2000; POLICY II, 2000–2006), we need to look back critically at advocacy networks that POLICY formed or supported and identify what worked or did not work, and use these experiences to inform future initiatives in policy change and implementation. The framework that is used to undertake the critical analysis follows.

Analytical Framework

Components of Policy Change

Walt and Gilson (1994) emphasized that there are four main components of policy change—context, content, process, and actor—yet most policy analyses focus on content while neglecting context and process and, more so, actors. This framework was used by Valenzuela et al. (1999) to stress broader stakeholder participation in reproductive health policymaking. Stover and Johnston’s (1999) study on HIV policy formulation in Africa identified the key roles played by various actors during specific stages of the policy process. Hardee et al. (2004) described the “policy circle,” centered on a given problem and its potential solutions, as involving people and institutions, processes, programs, pricing, and performance. The foregoing studies form the basis for the framework that is used in this paper to analyze networks that advocated for FP/RH, maternal health, and HIV policy change.

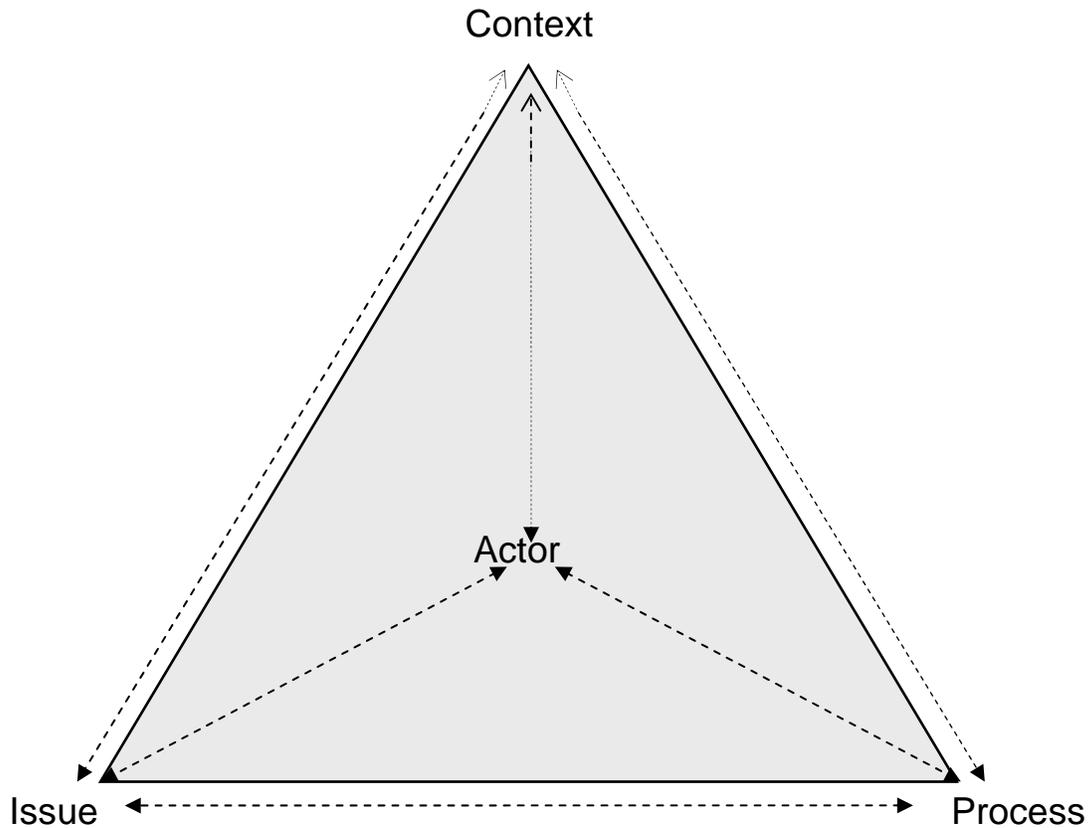
Figure 1 (adapted from Walt and Gilson, 1994) provides a graphic depiction of the main components of policy change: issue, context, process, and actor. “Issue” refers to a problem that has public health consequences and requires policy action. Many developing countries today face population/reproductive health issues that include high fertility and high-risk childbearing, low contraceptive use, unmet family planning need, slow declines in maternal and infant mortality, poor adolescent health, and, particularly in the last decade, HIV. In countries aligned with the former Soviet Union, reproductive health challenges aside from HIV include very low fertility levels resulting from long-term societal reliance on abortion as a family planning method in the absence of wide access to modern contraceptive information and services. Furthermore, as the world focuses on Millennium Development Goals, reproductive health concerns have become couched in terms of poverty reduction.

“Context” shapes an issue; it refers to the broader socio-cultural, political, and economic environment that affects the problem and its potential solutions. Context defines a country’s values and aspirations as well as its development priorities, policies, and programs, and the process through which these are developed.

“Process” refers to the formal and informal stages of policy development and implementation. The policy process encompasses how problems are identified and solutions are proposed, how issues get on the formal agenda of policymakers, how a policy draft emerges from different proposed solutions, how decisions are reached in the formal policy arena, whether and how a policy decision is translated into an operational program or plan, how the program or plan is funded, and whether and how it is implemented (Bryson and Crosby, 1992; Meier, 1991). The policy process also includes evaluation to determine the

effectiveness of policy action or the need for reform (Stover and Johnston, 1999). The complexity of social processes makes the actual policy process non-linear and iterative (Porter, 1995), although the process is described in stages for analytical purposes.

Figure I. Components of Policy Change



Note: Adapted from Walt and Gilson, 1994

Two processes, data collection and advocacy, can occur through the entire policy process. Data are needed to identify problems, review alternative solutions, determine resource requirements, make decisions, guide activities, and evaluate accomplishments. Data on a specific concern, however, may be unavailable or not easily accessible. Statistics or research findings may be ignored. Advocacy refers to a set of targeted actions directed at policymakers and key stakeholders to support a specific policy issue (POLICY Project, 1999). Advocacy occurs within or outside the formal decisionmaking arena since it aims to influence the entire policy process or stages of the process that are open to outside intervention. Data and advocacy are interlinked: data can inform or strengthen advocacy, while advocacy can raise awareness about the importance of evidence-based decisions.

“Actor” refers to individuals and institutions that are involved in a specific policy initiative. Policymakers traditionally come from the highest levels of power and government; societies differ in terms of who can and does participate. Some policy specialists point to issue identification as the most critical stage of policymaking because who defines an issue and how it is framed determines what types of solutions are

proposed or adopted (Bryson and Crosby, 1992). Problems that are not well defined may end up with solutions that do not really address existing problems (Kingdon, 1984; Porter, 1995). A policy reform initiative may not take off because those most affected—implementers and clients—were not involved in framing the problem or policy response.

The preceding paragraphs point to the interrelatedness of the components of policy change, with actors at the center. Context influences which actors can participate in the policymaking process, the resulting decision, and also whether a policy is implemented at all (Grindle and Thomas, 1991). Actors define issues based on their own individual and group backgrounds and perceptions of the broader political-social context. Actors interact on specific issues and, if some common ground is reached, such interactions can lead to concerted efforts to change policy processes or influence policy decisions. As actors influence policy decisions and their implementation, the broader political/socioeconomic context is gradually transformed.

Networks as Policy Actors

Combinations of actors and stakeholders can represent varied interests and backgrounds, such as civil society, government institutions, non-government groups, and industry (Altman and Petkus, 1994). Our analytical framework focuses on networks as key actors in promoting policy reform. Numerous development challenges competing for limited resources give rise to the need for organized mechanisms, such as coalitions or networks,¹ to achieve a range of outcomes beyond the capacity of any single organization. Networks can provide the structure for organizations and individuals to maximize the power of numbers through resource sharing and wider reach to raise awareness about critical problems and influence policy decisions (POLICY Project, 1999). Networks and coalitions can build consensus and ownership across various levels of society for FP/RH policy change and implementation. Networks that succeed in influencing high-level leaders may be asked to join the review or decisionmaking process. Broad-based coalitions can make civil society truly a part of decisionmaking at national and local levels—a governance landmark in itself. The same can be said of networks being involved in strategic planning and financing processes. Civil society networks representing or including members from vulnerable and marginalized groups can facilitate efforts to ensure that programs and services reach those most in need.

Networks can also function as mechanisms to facilitate policy implementation and review. Policy implementation itself involves various stages: legitimization, constituency-building, resource mobilization and allocation, organizational structure, mobilizing for action, and monitoring (USAID Center for Democracy and Governance, 2000; Brinkerhoff and Crosby, 2002). Whether to ensure that a “good” policy gets implemented or after successfully advocating for a specific policy action, networks can help legitimize the policy by raising awareness among members and other community groups about the policy’s rationale, objectives, and desirability. Compared to one single NGO or interest group, coalitions composed of several NGOs and groups have better chances of getting the attention of high-level leaders and achieving desired policy changes. This is especially important when sensitive issues are involved, often the case for FP/RH and HIV in many countries. Constituency-building requires active support from those who consider the policy necessary and are willing to engage others to support the policy and initiate action. Broadening awareness and support among various groups helps widen ownership of the policy and foster transparency on the part of policymakers and implementers. The challenge is to avoid politicization of the policy (Hammergren, 1998), and ensure sustained support for its implementation beyond political administrations and despite opposition from other groups.

¹ While some organization experts distinguish between networks and coalitions, this paper uses the terms interchangeably to refer to alliances or umbrella groupings of organizations and individuals supportive of FP/RH, HIV, and maternal health issues.

Networks can also serve as catalysts for action—for political leaders to act and for committed constituencies to translate intent into result. Finally, networks and coalitions can monitor policy implementation to ensure progress and accountability.

Elements of Effective Advocacy Networks

Considering the varied pathways to policy change and implementation, and the different environments and challenges that networks face, there is a need to understand what makes networks work and what they do to influence policy reform effectively. Theoretical approaches, case studies, and manuals or handbooks of community organization experts and US-based and international advocacy groups identified most or all of the following as the elements of effective advocacy networks and coalitions:

- shared mission/goal;
- a unifying issue and common strategy;
- representation and active membership;
- widespread commitment from among network leaders and members;
- inclusiveness;
- public engagement;
- human and financial resources; and
- technical and organizational competence.

Of the foregoing, one of the most emphasized factors is a shared mission or goal that incorporates the self-interests of constituencies while encompassing something larger than self-interests (Cohen et al., 2002; Druce and Harmer, 2004; McKinsey and Company, 2002; Potapchuk and Cracker, 1999). To be effective, networks and coalitions should have a clear and unifying issue and a well-defined common strategy to address that issue (POLICY Project, 1999). Commitment and ownership for the goal, issue, and the alliance itself should exist throughout the network, from leaders to members. Available literature also emphasizes that coalitions should have diverse membership, although membership is often driven by the coalition's goals. A citizen's network for civil society participation may only consist of NGOs and people's organizations, while public-private coalitions often consist of government and non-government institutions. Coalitions with less diverse membership may communicate and work more quickly because members' interests and objectives tend to be more alike, but such groupings may be weaker in their ability to appreciate other factors that contribute to the problem that lie beyond the purview of member organizations (Cohen et al., 2002). Moreover, engaging other groups or soliciting broader support may be difficult. Although diversity is recommended, advocacy coalitions do need to have genuine representation from those most directly affected by the issues that the coalition addresses. Representation cultivates credibility and leverages accountability (Brown, 1984).

Inclusiveness encompasses membership, communication, and capacity building. At the start, however, a coalition may be smaller as the group identifies a common purpose, but once accomplished, broadening the coalition can be a major strategy (Cohen et al., 2002). Coalition building often involves reaching out to two power extremes in the community (Foster and Wolff, 1993): the most powerful (e.g., government officials, religious leaders, big business) and the least powerful (e.g., grassroots associations, women, youth, the poor, marginalized sectors, indigenous groups, etc.). Multisectoral coalitions are more likely to garner support for public policy initiatives from various groups than closed or exclusive organizations. Even when membership of a coalition has been formalized, coalitions must engage not just their own members but also the broader society. Public engagement helps establish some common ground with other groups that may not join the coalition formally, but can be counted on for some level of support.

Building broad and visible public support for the coalition's issue and goal can strengthen political will and spur action among government and community leaders (Potapchuk and Cracker, 1999).

Technical competence underlies effective networks (POLICY Project, 1999 and 2005). Technical skills include familiarity with an issue and its national and local trends, underlying causes, and impact on people's lives. Networks also need to have some level of understanding of the context surrounding their chosen issue, including the policies affecting the issue, policymaking processes, and decisionmakers and other stakeholders along with their position on the issue. Because of the social issues that they espouse, advocacy networks should have the skills to effectively dialogue with various groups, including the most vulnerable, to ascertain and understand their needs and ensure that these are well framed and represented in advocacy initiatives. Technical competence also includes the ability to present information about a specific issue to various groups in order to raise awareness and elicit support. Evidence-based problem statements and policy proposals promote positive image and credibility.

The elements that contribute to the organizational competence of networks include leadership, decisionmaking structures, human and financial resources, communication systems, and planning skills. Ideally, leadership should allow for broad participation, delegation of authority, and accountability to the whole network. Hence, shared leadership is often recommended, rather than hierarchical structures (POLICY Project, 1999). Moreover, leadership also means building capacity of new leaders to ensure continuance and avoid dependence on a few individuals (Centre for Development and Population Activities [CEDPA], 1999; Kellogg Foundation, 1999; Potapchuk and Cracker, 1999).

Cohen et al. (2002) cited the need for coalitions to have staff to ensure continuing attention in addition to volunteers to encourage collaboration. Organizational competence is demonstrated as well in the ability to generate and use financial resources to further the entire network, not just a single member. This is especially important at the beginning of network building to allow relationships to be strengthened, to reach agreement about the shared goal, and to achieve early successes for the network as a whole (Foster and Wolff, 1993). Communication systems should facilitate linkages not just among members but also between the coalition and the government, other coalitions, and civil society groups. The coalition should serve as a forum for sharing information (Cohen et al., 2002). Review and planning skills are also needed to determine accomplishments, the benefits of belonging in the network, leadership, decisionmaking, communication, membership, resources, and next steps (Black, 1983; Cohen et al., 2002; POLICY Project, 1999).

These identified elements of effective networks provide the basis to explore what selected networks did to effectively influence reproductive health policy reform.

Definitions, Data, Methodology, and Limitations

“Network” and “coalition” are used interchangeably in this paper. Both refer in a generic sense to a formal or somewhat formal grouping of organizations and individuals that agree to form an alliance and work together to achieve a common goal. Also, this paper uses “reproductive health” in a generic sense to encompass all reproductive health concerns, be these for family planning, contraceptive security, maternal health, or HIV services. Hence, the phrase “RH networks” refers to networks that advocated for various reproductive health concerns, as distinguished from say HIV coalitions or networks of people living with HIV that might focus primarily on HIV-related stigma and discrimination issues.

Policies are broad statements of objectives, intentions, and mechanisms for action (Brinkerhoff and Crosby, 2002; Walt and Gilson, 1994). Public or government policies encompass both national policies and laws that provide the framework to guide a country's future courses of action, as well as operational

policies such as regulations, strategies and plans, budgets, administrative norms, and procedures that help national and local governments translate national policies into programs and services (Cross et al., 2001).

For purposes of this paper, network effectiveness is ultimately assessed in terms of a network or coalition actually influencing policy reform and implementation to increase access to quality FP/RH/HIV/maternal health services. Network influence could have occurred at any stage of the policy process—at the initial stage of identifying problems and raising awareness about the need for policy action, during policy formulation and review, when final decisions are made, during program planning and financing to operationalize the policy, or during policy implementation and evaluation.

POLICY's networking approach to advocacy recognizes that there are numerous ways to influence policy reform. By targeting advocacy campaigns to leaders and mobilizing support for their campaigns among communities and other groups in society, networks can help pave the way toward policy change and implementation by achieving the following:

- Political commitment and popular support for FP/RH/HIV/maternal health policies and programs
- Civil society participation and representation in the policymaking process
- Public-private partnerships for policy reform and implementation

These three outcomes are interrelated. Coalitions that are widely supported by various civil society groups are more likely to draw the attention of public officials and foster political commitment. Networks that succeed in reaching and influencing high-level leaders can also advocate for the policymaking process to be opened to broader participation, including marginalized groups. Instead of policy initiatives being led by government, ownership for such initiatives can expand and public-private partnerships may result.

The main sources of data for the case studies are POLICY documents, such as the country and project-wide quarterly and semi-annual reports, country briefs, and memoranda together with copies of official documents to support reports of results that were achieved in various countries. Other data came from studies and reports prepared by local project staff, partner networks, and NGOs; government documents; POLICY working papers and studies; and other sources, such as photographs, videos, brochures, and newspaper clippings. Country statistics are taken from national census reports as well as demographic, health, or reproductive health surveys undertaken by country partners with USAID support through Macro International or the Centers for Disease Control and Prevention.

Between September 1995 and June 2005, during POLICY I and II, the project assisted civil society or multisectoral groups in about 40 countries to form and/or develop over 100 networks and coalitions to advocate for FP/RH, adolescent reproductive health, maternal health, or HIV issues (see Table 1). In terms of numbers within a country, the majority of countries had one RH network that received POLICY support. A couple of countries had over 10 advocacy networks assisted by POLICY, with Peru having the most networks (25) during 2000–2005.

POLICY provided technical assistance to national as well as regional or district-level networks. Local networks were often supported in the case of countries that were in the process of decentralization, where policy development, planning, and/or funding responsibilities were being transferred to local authorities. Most national and local networks focused on a broad array of reproductive health concerns including family planning, adolescent health, safe pregnancy and childbirth, and, in some countries, HIV. Networks of people living with HIV were more focused on HIV-specific concerns. Peru had 16 networks promoting reproductive health and women's health and nine HIV coalitions. South Africa had 12 networks, all focusing on HIV issues.

Most of POLICY's technical assistance to networks focused on advocacy training, small grants for network-building and/or advocacy activities, and support to advocacy campaigns. Combinations and sequences of technical assistance that POLICY provided depended on country and network needs, and the availability of USAID and other international or local donor support.² The types of assistance to networks included:

- Organizational planning workshops, small grants,³ and technical assistance to form or develop networks and coalitions, especially in countries or localities where there were few NGOs or no organized civil society-led advocacy networks.
- Curriculum development and implementation of training workshops on advocacy, using *Networking for Policy Change: An Advocacy Training Manual* (POLICY Project, 1999) and issue-specific supplements on maternal health (2003), contraceptive security, and adolescents.⁴
- Reports, resources, and tools on various FP/RH/HIV/maternal health issues and on advocacy that were developed by POLICY staff and other groups all over the world.
- Training-of-trainers (TOTs) on coalition-building and advocacy, especially for networks that expanded to various regions in their respective countries to facilitate "cascade" training.
- Small grants to develop and implement advocacy campaigns.
- Technical seminars, briefings, and workshops to increase knowledge about FP/RH issues.
- Ongoing support in implementing and monitoring advocacy strategies and activities.
- Assistance in undertaking local data gathering and policy analysis for advocacy purposes.
- Support in policy dialogue with government and non-government entities at the country level.
- Workshops on strategic planning, sustainability, and evaluation.

When resources permitted, POLICY translated advocacy manuals, supplements, and issue briefs into local languages. In a few countries, networks used the results of computer models developed by POLICY in their advocacy initiatives. To facilitate south-to-south exchanges of best practices and experiences, seasoned advocacy leaders from certain networks were also involved in advocacy workshops conducted in other countries.

In the next section, 11 brief country case studies are presented that analyze specific networks that figured in policy change initiatives in order to identify the factors that made RH networks effective policy champions. Where possible, the paper also provides some insights on what did not work using available project records, feedback from networks themselves or their partners, and anecdotal evidence provided by local counterparts and POLICY staff. Some of the case studies were based on more extensive network case studies or country final reports prepared under POLICY I or II. The remaining case studies were compiled by the author based on existing country workplans and reports submitted by networks or country staff to POLICY/Washington.

²The case studies specify other donor support where relevant or appropriate.

³Please refer to "POLICY II Project: Small Grants ... Big Impacts" (POLICY Project, 2005) for a more extensive report on small grants.

⁴POLICY's advocacy training manual for networks, *Networking for Policy Change*, will hereafter be referred to simply as the advocacy training manual. While only the maternal health supplement (POLICY Project, 2003) has been printed, networks in various countries have been provided drafts of the other supplements to use during advocacy training. Feedback from the field is being used to finalize the supplements. The contraceptive security supplement is forthcoming.

Table I. Networks Formed and/or Assisted by POLICY, 1995–2005

REGION/COUNTRY	NUMBER OF NETWORKS	FOCUS OF ADVOCACY INITIATIVES
AFRICA		
Benin	1	RH
Ethiopia	1	RH/maternal health
Ghana	6	RH/adolescent reproductive health
Kenya	3	HIV
Mali	2	RH
Malawi	1	HIV
Nigeria	9	RH (8), HIV (1)
Sahel Region	1	RH
South Africa	12	HIV
Southern Africa	1	HIV
Swaziland	1	HIV
Tanzania	4	RH/maternal health (1), HIV (3)
Uganda	2	RH*
Zambia	2	HIV
ASIA & NEAR EAST		
Bangladesh	1	RH/maternal health
Cambodia	9	RH (1), HIV (8)
Egypt	1	RH
India	1	maternal health
Jordan	1	RH
Mekong Region	1	HIV
Nepal	2	HIV
Philippines	6	RH
Vietnam	1	HIV
EUROPE & EURASIA		
Romania	4	RH
Russia	6	RH
Turkey	1	RH
Ukraine	2	RH (1*), HIV (1)
LATIN AMERICA & THE CARIBBEAN		
Bolivia	1	RH
Guatemala	2	RH
Honduras	1	HIV
Mexico	3	HIV
Peru	25	RH/maternal health (16*), HIV (9)
TOTAL	114	

Source: POLICY database based on country reports.

*Refers to a national network with local branches, affiliates, committees, or chapters.

COUNTRY CASE STUDIES

Various networks and coalitions helped influence FP/RH, maternal health, and/or HIV policy and program development and implementation in Africa, Asia, Eastern Europe, and Latin America. The case studies presented below are constructed from a country perspective to provide the broader context of what networks and coalitions did, with technical assistance from POLICY, to advocate for specific reproductive health issues. The case studies focus on a network or several networks as a key actor(s) in influencing policy processes, including awareness raising of policy challenges, policy development, decisionmaking, and implementation.

Figure 2 presents a map of the case study focus countries and networks. Table 2 provides an overview of the key elements of each country case study and highlights the networks' area of focus and advocacy issue(s), contextual factors shaping the issues and in which advocacy took place, activities undertaken by networks in their advocacy campaigns, policy-related results attributed to networks, and key factors that made networks succeed. The complete case studies follow.

Figure 2. Map of Case Study Focus Countries and Networks

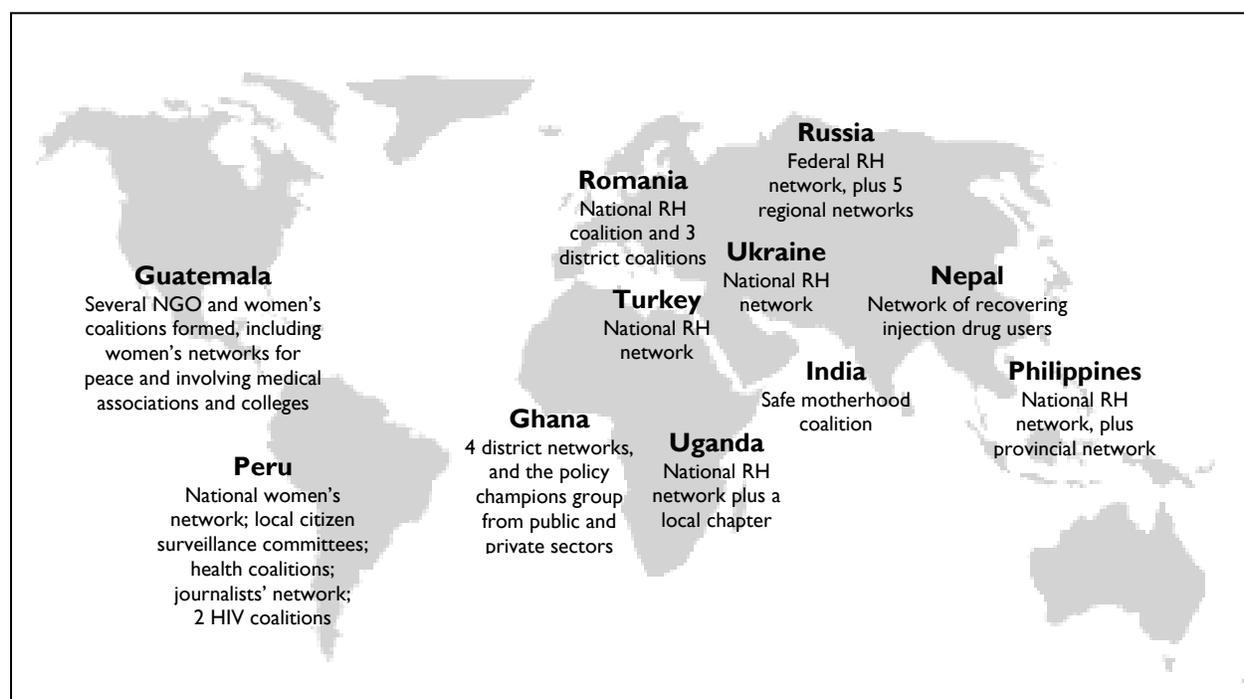


Table 2. Country Networks, Key Advocacy Processes, and Results

Country and Networks	Key Issue(s)	Main Components of Advocacy Campaign	Contextual Factors	Policy-related Results	Factors Supporting Success
GHANA 4 district networks; Policy Champions Group	Population/FP/RH	Data collection; information, education, and communication (IEC); awareness-raising; workshops; development of champions	Young population; total fertility rate (TFR) = 4.4; low contraceptive use; generalized low adult HIV prevalence (2.2%); decentralization	<ul style="list-style-type: none"> • Adolescent health incorporated into district budgets/plans • 3 youth-friendly centers established • FP integrated into HIV, child health, and environment programs 	<ul style="list-style-type: none"> - Public-private collaboration - Multisectoral representation - Competence, commitment - Leveraged local resources - Fundraising - Implementing members ensured sustainability - District-level policy champions
UGANDA Uganda RH Advocacy Network (URHAN) URHAN/Hoima chapter	Adolescent reproductive health (ARH) Early marriage	Survey of ministries on barriers to ARH programs; meetings with members of Parliament and ministries on survey results National URHAN formed district branch; local network targeted advocacy to King of Bunyoro	Young population; TFR = 7; generalized HIV prevalence (~6%), with more youths and women newly infected; high poverty; limited resources; decentralization High incidence of early pregnancy and marriage; low political commitment to RH and ARH in the district	<ul style="list-style-type: none"> • Participatory policymaking • ARH policy approved • Uganda Muslim Supreme Council reviews its internal policies on marriage • Revised Church of Uganda early marriage law (18+ years old) • King championed ARH and funded an educational initiative for girls 	<ul style="list-style-type: none"> - Multisectoral representation - High-level national officials endorsed URHAN - Faith-based organization champions - Member organizations demonstrated commitment to ARH by reviewing their own internal ARH policies - King championed ARH and partnered with URHAN
NEPAL Recovering Nepal	Injecting drug users (IDUs) and HIV	Awareness raising on injecting drug use, people living with HIV, stigma and discrimination, and the need to fund services; media outreach	Low, concentrated HIV epidemic (0.5%); stigma and discrimination against IDUs and people living with HIV; internal political conflict; TFR = 3.7	<ul style="list-style-type: none"> • Donor policies revised to allow vulnerable groups to apply without restrictions • IDUs participated in the IDU/HIV policy and plan development 	<ul style="list-style-type: none"> - IDU participation in national policymaking - Capacity building expanded ownership among marginalized groups - Partnerships with policymakers, media, and providers

Table 2. Country Networks, Key Advocacy Processes, and Results

Country and Networks	Key Issue(s)	Main Components of Advocacy Campaign	Contextual Factors	Policy-related Results	Factors Supporting Success
INDIA White Ribbon Alliance–India (WRAI)	Safe motherhood (SM)	Data collection, analysis, and presentation to Government of India (GOI), ob-gyns, and NGOs; showcasing SM during public events; identification of gaps in GOI midwifery standards	TFR = 2.9; high maternal and infant mortality; 42% contraceptive prevalence rate (CPR); concentrated HIV prevalence (0.9%)	<ul style="list-style-type: none"> • WRAI leadership in regional advocacy (per World Health Organization request) • WRAI assisted GOI in developing RH and child health program • WRAI helped ministry to develop maternal and child health guidelines • Guidelines launched 	<ul style="list-style-type: none"> - Broad, multisectoral membership - Support from global WRA - Ability to bring community issues to top decisionmakers - Focus on a single key issue - Use of public events on a significant day to promote SM
PHILIPPINES RH Advocacy Network (RHAN) Advocates for Better Living (ABLE)–Pangasinan	National contraceptive security (CS) CS in province of Pangasinan	Survey of FP opinions among province’s decisionmakers; dialogue with key stakeholders; use of population data and economic arguments for CS	National TFR = 3.5; high unmet need; phaseout of USAID contraceptive donations; weak national support for FP; religious opposition to FP Decentralization law allows local governments to decide on CS; governor and local partners want to ensure wide access and choice	<ul style="list-style-type: none"> • Contraceptive funds allocated in 7 municipalities and 2 cities • CS line item in Provincial Population Office budget • National Department of Health created CS Technical Working Group 	<ul style="list-style-type: none"> - Governor partnered with NGOs and advocated to municipal officials - Local success demonstrated to national-level decisionmakers the need to fund CS
ROMANIA RH Coalition (national) 3 district RH coalitions	RH CS	Social mobilization through public events to promote women’s health through improved access and funding Data-based advocacy to district decisionmakers to champion RH/CS to national policymakers	High maternal mortality (due to reliance on abortion for FP); the poor have low contraceptive access; historically centralized decisionmaking, but embarked on new decentralization policy and health sector reform	<ul style="list-style-type: none"> • RH included in national health insurance package • Ministry of Health (MOH) budget for contraceptives • Free contraceptives for the disadvantaged • National health insurance coverage of generic oral contraceptives and injectables • Government approved self-certification of poverty status • Norms for NGO involvement in public health developed 	<ul style="list-style-type: none"> - Multisectoral coalitions - High-level government champions - Deeper understanding of CS - Network collected data that was fed back to the MOH - Community mobilization for wider support spurred local leaders to advocate to national policymakers - Close personal/professional ties among network members

Table 2. Country Networks, Key Advocacy Processes, and Results

Country and Networks	Key Issue(s)	Main Components of Advocacy Campaign	Contextual Factors	Policy-related Results	Factors Supporting Success
<p>RUSSIA</p> <p>Federal advocacy network for RH</p> <p>5 regional networks</p>	<p>FP/RH/ maternal health (MH)</p> <p>FP/RH, CS, and ARH</p>	<p>Letter-writing; roundtable with national policymakers; RH training for media; publication and presentation of RH edition of academic journal to Duma</p> <p>RH-focused newsletters and publications; expanding network membership; data collection; partnerships with public sector officials</p>	<p>High maternal mortality; abortion as FP method; TFR =1.4; high incidence of sexually transmitted infections (STIs); low national/local awareness about RH impact on the health of the population; geographic expanse; devolution policy</p>	<ul style="list-style-type: none"> • State Duma Commission on Population and Development co-sponsored RH edition of journal • Subsidized public transport, supplements, medicine for poor • RH services expanded for males • Oblasts approved youth/child health and RH programs • Oblasts approved 2 policies, 5 ARH/FP/STI prevention decrees 	<ul style="list-style-type: none"> - Multisectoral partnerships - Members' ownership of federal network fostered development of regional networks - TOT at regional level cascaded into local capacity building - Small grants facilitated start-up and capacity building of local networks
<p>TURKEY</p> <p>NGO Advocacy Network for Women (KIDOG)</p>	<p>CS</p>	<p>Network launching at United Nations global conference; media exposure; meetings with government officials; public information campaign to stimulate demand and promote quality of care</p>	<p>TFR = 2.6; rising FP demand; lack of political will for FP/RH; young, uncoordinated NGO sector; low public-NGO collaboration; USAID phaseout</p>	<ul style="list-style-type: none"> • President ordered MOH to mobilize funds for government procurement of contraceptives • NGO participation in public policy and plan development 	<ul style="list-style-type: none"> - Training, small grants, and advocacy enabled NGOs to understand and monitor the policy environment - Personal contacts facilitated access to key decisionmakers - Media involvement
<p>UKRAINE</p> <p>Ukrainian Reproductive Health Network (URHN)</p>	<p>National RH Plan (NRHP), CS, MH, youth access</p>	<p>Network identity through targeted public information campaign; creation of national directory of RH NGOs to facilitate local partnerships; participation in multisectoral policy dialogue</p>	<p>High maternal mortality; use of abortion as FP method; low life expectancy; social and economic instability; out-migration; high STI incidence; concentrated HIV epidemic (1.4% prevalence); high-level RH policymaking</p>	<ul style="list-style-type: none"> • National RH Plan approved in 2001 • RH Policy Guide drafted and distributed to oblasts and ministries • Safe Motherhood Concept approved, with URHN assistance • Ministry of Education increased classroom time allocated for ARH • Increased implementation and funding for NRHP at local level • Broader civil society involvement in HIV policymaking 	<ul style="list-style-type: none"> - Multisectoral membership - Strong commitment to common goal - Members' willingness to volunteer time/resources - Teamwork and open sharing of information and experiences - Public-private partnership increased network's credibility and fostered civil society participation in policymaking

Table 2. Country Networks, Key Advocacy Processes, and Results

Country and Networks	Key Issue(s)	Main Components of Advocacy Campaign	Contextual Factors	Policy-related Results	Factors Supporting Success
<p>GUATEMALA</p> <p>Broad, temporary alliances made up of women's networks, medical associations, medical colleges, and other NGOs</p>	<p>National RH Program (NRHP)</p> <p>Government RH policy and funding</p>	<p>Joint press releases; RH awareness raising among key stakeholders; for the elections, dialogue with political parties on their RH agenda; public media dissemination of RH agendas of political parties</p> <p>Meetings with government officials to present population projections, cost analyses, and international agreements; dialogue with officials on alliance's RH/MH proposals</p>	<p>TFR = 4.4; high maternal and infant mortality, especially among rural and largely indigenous populations; lack of high-level support for FP/RH; religious opposition to FP; changing political landscape in the transition to peace after long, violent civil war</p>	<ul style="list-style-type: none"> • NRHP launched in 2000 • Law of Social Development approved by Congress; Social Development Population Policy issued by government in 2002 • Health budget increased by Congress • Congress approved 15% tax for child, RH, and alcoholism programs • MOH published "Basic Guidelines and Health Policy" • Institute for Social Security reinstates FP/RH into postpartum services covered by insurance 	<ul style="list-style-type: none"> - Multisectoral alliances included medical and non-FP groups - Strong commitment of members - Consistent focus on a single issue - Use of a unified, well-tested strategy - Vigilant monitoring of changes in policy environment and challenges to achieving goals
<p>PERU</p> <p>RNPM (national women's network), local citizen surveillance committees (CSCs), ForoSalud coalitions</p> <p>Journalist network</p> <p>Colectivo por la Vida, Peruvianos Positivos</p>	<p>FP/RH/MH, women's access and quality of care, patients' rights</p> <p>Promotion of patients' rights; Needs and rights of people living with HIV</p>	<p>Citizen participation in health policymaking and monitoring of quality of care and compliance by forming and training local CSCs; participatory policy dialogue and soliciting public feedback; evidence-based health policy dialogue and action</p> <p>Dissemination of public messages through media spots</p> <p>Formation of regional networks of people living with HIV; press conferences; awareness raising about HIV and prevention</p>	<p>High poverty; high maternal and infant mortality especially among rural poor; TFR = 2.7; evolving FP/RH policy environment with decentralization and health sector reform (from free FP but with coercive targeting of the poor, to conservative anti-FP with multiple barriers to access); health policy guidelines and strategic plan set priorities for mother and child care, but not FP or HIV</p>	<ul style="list-style-type: none"> • MOH approved Health Policy Guidelines for decentralization; formed National Health Council, which includes civil society, for policy formulation and coordination • Tomayquichua municipal authority funding for MH • ForoSalud became official civil society representative on National Health Council • ForoSalud's situation analysis included in regional health plan • ForoSalud elected to Junin Regional Health Council • Trujillo Regional Hospital created an office to improve quality of care and relationships with civil society • National Congress approved Article 7 of current AIDS law granting free services/medication for people living with HIV and prohibiting discrimination against them 	<ul style="list-style-type: none"> - Using innovative approaches to decentralization to improve access - National networks formed regional or local networks or chapters - Active civil society participation in monitoring policy implementation and serving as mechanisms for feedback helped ensure timely policy action



GHANA: District Networks Support Decentralized Reproductive Health Programs⁵

Along with numerous economic development challenges, Ghana has been affected by several related problems including high fertility, rapid population growth, low contraceptive use, and high maternal and child mortality. HIV is another concern. Ghana is presently a generalized, low-prevalence country per UNAIDS definition. HIV prevalence among patients with sexually transmitted infections (STIs) and blood donors is 17 percent and 4 percent, respectively. The 2002 Ministry of Health (MOH) sentinel survey, however, indicated rising HIV prevalence since 2000.⁶ Prevalence exceeded 5 percent in six sites.

Ghana's policies generally support access to reproductive healthcare services: the constitution guarantees reproductive healthcare access and the revised National Population Policy supports public-private sector cooperation in policy and program development and implementation at national and subnational levels. Like many countries, the problem lies more in reproductive health policy implementation. While decentralization tends to emphasize public-private collaboration, it also complicates the situation. Decentralization started in the 1990s and resources were allocated to 110 districts, with District Assemblies (DAs) implementing programs locally. The National Population Council (NPC) coordinates the national population program, in collaboration with multisectoral Regional and District Population Advisory Committees. Resource constraints and ineffective implementation continue to affect the reproductive health sector. With decentralization, the challenge is ensuring that FP/RH is a priority for local governments, NGOs, communities, and civil society groups.

Consolidating Civil Society Representation. Ensuring civil society participation and public-NGO collaboration in population/reproductive health policy and program development was a challenge as decentralization efforts got underway. Strong NGOs and community-based organizations (CBOs) existed, but they did not have a common platform to share information and coordinate with government systematically. In 1996, the NPC and POLICY piloted a project to help local NGOs/CBOs to form district advocacy networks. POLICY's participation coordinator worked with NPC, the MOH, and other groups to initiate the effort. The Eastern Region was chosen as the pilot area because it fit the criteria of NPC presence, proximity to the capital, and NGOs interested in linking with other reproductive health stakeholders. To access local affiliates, meetings were held with NGOs such as the Planned Parenthood Association, Red Cross, National Youth Council, Council of Women and Development, Ghana Education Service, Muslim Association, transport union, and national associations of midwives, teachers, lady pharmacists, and women in the media.

Network Formation and Capacity Building. Six networks were formed in five districts in the Eastern Region: New Juaben, Suhum-Krabo-Coaltar, Kwabibirem (Kade and Akwatia subdistrict networks), Akwapim South, and Akwapim North. The network formation process started with a district inaugural meeting to bring together NGOs, CBOs, and government representatives to forge agreement to form an RH network for the district. Once a network was formed, members elected officers, drafted by-laws, and set up executive committees and task forces. Networking and advocacy workshops were conducted to help the new networks identify district concerns, develop mission statements, select advocacy issues, formulate advocacy strategies, and develop action plans. Other workshops aimed at strengthening the networks' technical competence on reproductive health, gender, community mobilization, sustainability,

⁵ Based mostly on Dickerson (2003) and Parkes (2005).

⁶ Ghana Health Service, Ministry of Health (2003).

using the AIDS Impact Model (AIM), training of trainers, materials development, fundraising, proposal writing and budgeting, and administering POLICY small grants.

Awareness-raising Activities. The networks worked with the Regional Population Officer and Regional Population Advisory Committee (RPAC) to help the NPC achieve its mission of raising awareness of population/FP/RH issues at the district level. This was easily done because several RPAC members were also members of the networks. Due to limited district-level data, four networks conducted baseline surveys (Suhum and New Juaben in 1997, and Akwatia and Kade in 2000) assisted by the NPC, the Population Impact Project, and POLICY. Network members administered questionnaires and those with technical background analyzed the data. Other networks used records from hospitals, schools, and the MOH. The data were used to prepare information, education, and communication (IEC) and advocacy messages, fact sheets, newsletters, and presentations. Members with technical expertise and strong public speaking skills were chosen to deliver advocacy messages, often focused on integrating adolescent health issues into district plans and budgets.

The networks then proceeded to identify NGOs and CBOs in their districts: church organizations and Muslim groups, women's groups, organizations representing in- or out-of-school youth, trade unions, and professional associations. Network members formed task forces to meet with district groups, provide regular updates, and deliver presentations on family planning, HIV, and adolescent reproductive health. Advocacy presentations were targeted to the District Chief Executive, the Executive Committees, chiefs and elders, heads of religious institutions, and opinion leaders. The primary target audiences across districts were the leaders and influential individuals in the DAs. Network members, who were mostly volunteers, often met and worked together beyond official work hours to plan for their meetings with DAs. After the presentations, these leaders often asked the networks to speak to their people. Often, a *durbar* (tribal conclave) of chiefs and local decisionmakers was the audience for the presentations. Aside from sensitizing communities and district assemblies, the networks also solicited local groups' input and support through focus group discussions; meetings with imams; seminars for women's groups and youth leaders; and community meetings. Network members even traveled to remote villages for community meetings on reproductive health, HIV, and adolescent pregnancy. Whenever turnover or transfer of DA officials occurred, the networks returned to sensitize new leaders about critical FP/RH issues.

Sustaining Advocacy. The district RH networks continued undertaking local advocacy campaigns even after POLICY assistance to Ghana networks ended (around 2000) and well into the present. One reason the local networks continue to function is because many members are also implementers—some were local government program managers and providers, and several were family planning service delivery NGOs, associations, and provider groups—helping to sustain the networks' advocacy initiatives in their own areas. Another reason is that the networks conducted their own fundraising activities. The Kwabibirem and New Juaben networks applied for and received funding from GARFUND (funded through a World Bank loan) to undertake HIV advocacy. The New Juaben network is also implementing an HIV workplace program. The other local RH networks are awaiting approval of their funding proposals. Some networks received in-kind assistance (e.g., use of vehicle and equipment) from DAs or are seeking additional support from community members. The Kwabibirem district health office lends equipment for the local network's outreach activities. District managers gave the Akwapim South network an office to meet and display materials prepared by the network, and included the network's activities in the annual district health report.

Policy Champions Group. Four members of the RH networks from New Juaben, Kade, Suhum, and the Ghana Registered Midwives Association attended the POLICY-supported "Repositioning Family Planning in Africa Regional TOT Workshop" held in Accra in May 2003. The Ghanaian participants were so motivated that they formed "Policy Champions," an advocacy group to persuade DAs to incorporate family planning into current and future programming for the HIV and population funds that they

administer. The champions organized workshops for the Eastern and Central regions and conducted awareness-raising meetings and advocacy training for the MOH Ghana Health Service, District Health Management Teams. Workshops were also held with NGOs to advocate to decisionmakers at the district and lower levels to ensure resources for family planning.

Although fairly recent, the policy champions group has made significant headway in repositioning family planning. Local leaders of the government and NGO sectors led by the Eastern Regional Minister endorsed the integration of family planning into HIV and other programs to complement national development efforts. The African Youth Alliance decided to establish three youth-friendly centers at community centers, staffed by qualified health personnel to provide family planning services in selected districts, as well as fund adolescent health programs implemented by district teams in Kwahu South and East Akim. The Suhum subdistrict is undertaking family planning activities in collaboration with child health programs. Two CBOs in Kwaebibirem District—Friends of the Earth and the Hairdressers and Beauticians Association—incorporated family planning into their HIV prevention and environment programs.

Summary. Ghana shows that decentralization initiatives can provide impetus for a national coordinating body (in this case, the NPC) to collaborate actively with national and local NGOs to form and support advocacy networks for FP/RH/HIV. Networks were made up of members from government agencies as well as health and non-health NGOs. Significant network-building and advocacy support from POLICY strengthened the networks' capabilities. Multisectoral representation from government and CBOs in the network helped ensure active involvement and resources to keep FP/RH issues on the agenda of local decisionmakers. Despite limited resources, the networks continue to exist even until today, in part because members have sought and obtained funding from various sources in order to continue advocacy initiatives. Ghana also provides a model of advocacy networks with NGO and government members who are also program implementers, promoting FP/RH from policy to actual action.



UGANDA: Multisectoral Networks for Adolescent Health Policy Reform⁷

Ugandans ages 10–24 years comprise two-fifths of the country's total population of 27 million. Although Uganda is one of the world's success stories in combating HIV—and adolescent behavior change has contributed to HIV prevalence dropping by more than half since the early 1990s—young Ugandans face enormous challenges. The young account for half of all new HIV infections, with more than twice as many young women as young men being infected. Over half of all women are sexually active by age 17 and one-third of girls ages 15–19 are already mothers or pregnant with their first child. Education and employment options are limited. Although the economy advanced recently, productive employment remains out of reach for most young people, particularly in rural areas. Poverty levels remain high. Often, young people who do work are exploited. Political violence continues in the north, exposing young people to rape, abductions, family separation, displacement, and even death. Survivors are refugees with limited access to services, further compounding their low reproductive health status (Neema et al., 2004; YouthNet, 2004).

Several policies that support youth reproductive health issues already exist: the 2001 National Youth Policy that encourages youth-friendly health services, universal primary education, gender integration into development, and youth rights to voluntary counseling and testing (VCT); and HIV prevention programs that reduced cultural taboos and provided comprehensive family life education in schools.

⁷ The Uganda case study is based mostly on Rosen (2005).

NGOs, however, took the lead in providing reproductive health information and care for young people through media campaigns, training of health workers, advocacy, and provision of condoms and other methods of preventing pregnancy. Despite its potential reach, the public sector response has been limited, especially in rural and poorer areas. Decentralization has compounded challenges, as local resources and capacities are generally limited. Harmful traditional practices such as wife inheritance and gender discrimination persist.

Formation of Multisectoral Reproductive Health Coalition. In September 2000, 22 civil society organizations that included NGOs, women’s associations, media groups, religious organizations, cultural and professional associations, youth clubs, and HIV organizations that participated in workshops sponsored by the Population Secretariat and POLICY agreed to form an RH network. Uganda’s Vice President publicly endorsed the network and its mission of advocacy for FP/RH policies and programs that respond to the needs of women and men, including adolescents. The Uganda Reproductive Health Advocacy Network (URHAN) was formally organized at the end of 2001.

Advocacy for National Adolescent Health Policy. URHAN selected the inadequacy of youth-friendly reproductive health services as its advocacy issue and developed a plan to make youth reproductive health a priority for the MOH. URHAN’s objective was to gain approval of an adolescent health policy that was drafted in 1999 and that URHAN members and other stakeholders reviewed and endorsed to the MOH in 2002. Some ministries actually tried implementing adolescent health programs based on the draft policy, but clearly needed official mandates and authorizations for these programs.

To bolster its advocacy for youth-friendly reproductive healthcare services, URHAN conducted a qualitative survey of program managers in government departments and ministries—including Health; Education; Sports; and Gender, Labor, and Social Development—to determine whether and how the lack of an approved national adolescent health policy constrained the public sector’s ability to carry out youth-focused programs. Survey respondents identified numerous barriers resulting from the lack of an approved policy to guide implementation. URHAN used survey results and other data in raising youth health issues with members of Parliament and in calling for rapid approval of the draft policy to help eliminate barriers to access. The network also targeted key decisionmakers in the MOH and Ministry of Gender, Labor, and Social Development. URHAN focused particularly on the MOH through many face-to-face advocacy efforts. A high-ranking official of the ministry’s reproductive health unit became URHAN’s key champion and successfully pushed for an adolescent focus in the ministry’s reproductive health strategy. In January 2004, the official formed a committee, which included representatives from URHAN, to review the draft policy and revise as necessary.

Following advocacy by the network, the MOH approved Uganda’s first comprehensive National Adolescent Health Policy in October 2004. The goal of the policy is to mainstream adolescent health concerns in the national development process to improve the quality of life and standard of living of young people in Uganda. Viewed as a key step in facilitating the implementation of adolescent reproductive health programs throughout the country, the approved policy provides the official go-ahead for ministries to implement adolescent-related programs, a structure under which programs should be implemented, and the authority to allocate resources for these programs.

Organizational Policy Changes within URHAN Member Organizations. While waiting for policymakers to decide on the adolescent policy, URHAN members also worked to enhance policies of their own organizations. For example, a URHAN member, the Uganda Muslim Supreme Council, worked with an Islamic legal scholar to review its internal policies on marriage and reproductive health. In August 2002, the Church of Uganda supported a workshop for the Diocesan Secretary and Development Officers who proposed that the Church advocate against early marriages. This eventually led to a recommendation to amend the Canon Law. The law was revised by the Provincial Assembly of the

Church of Uganda at the Uganda Christian University. The revised Canon Law No. 2:31 raises the age of marriage from 16 years to 18 years, putting it in line with state laws. Church members subsequently participated in advocacy and TOT workshops in reproductive health. The trained advocates are currently working in 16 districts to form and train advocacy teams to sensitize bishops and local church officials.

Regional Advocacy for Reproductive Health. As a logical and needed next step, URHAN is now working at the district level, where advocacy has taken on greater importance because the responsibility for healthcare planning and resource allocation has been decentralized. URHAN formed its first chapter in Hoima District in December 2002. In March 2004, members participated in a workshop to enhance their capacity to implement an advocacy campaign. Members of URHAN from Kampala assisted with the workshop by introducing URHAN's protocols, mission statement, organizational structure, and communication tree. The Hoima network has 18 members representing civil society, local government, religious groups, youth clubs, family planning NGOs, and the Bunyoro Kitara Kingdom.

High incidences of early pregnancy and marriage are major causes of reproductive health problems. Political commitment to reproductive health, including adolescent health, remains low in Hoima District. Thus, URHAN/Hoima embarked on an advocacy campaign to reduce the incidence of early marriages in the district, which is part of the Bunyoro Kingdom. The King of Bunyoro was a primary audience; the network first focused on securing his commitment to ensure that marriage laws are adhered to within the kingdom. After pledging his support, the King requested URHAN/Hoima to assist him in launching a campaign to stop early marriages. The campaign was launched on October 1, 2005, on the palace grounds, attended by district dignitaries, religious leaders, NGO representatives, girls from various schools, and students from Makerere University who traveled from Kampala to act as role models. The Kingdom produced and distributed a pamphlet outlining the campaign's objectives, targets, and issues related to early marriage. The King cited data from research conducted by URHAN/Hoima on the incidence of early marriages and the negative impact on reproductive health in the district. The King also announced the formation of a Kabaleega Education Fund Committee that is tasked with raising funds to support education initiatives in the Kingdom, particularly for the girl-child. He also personally contributed to this fund.

Summary. URHAN's advocacy campaign for its first issue lasted three years. Garnering political support for the draft policy and finding a public sector champion required considerable effort and perseverance. Networking provided continuity to the multi-year effort; members became professional friends and supported each other to keep the momentum going. Having a policy champion in the MOH reproductive health unit was critical; the valuable ally was open to outside input, championed adolescent policy change, and ensured URHAN's inclusion on the committee to review and revise the draft policy. URHAN also showed that networking to influence national issues can benefit policies and programs of the advocates' own organizations. Experiences at the national level also provided the motivation to continue efforts at the regional and district levels.



NEPAL: Network of Recovering Drug Users Fosters Participation of Vulnerable Groups in the Policy Process⁸

The Nepal government estimates that the country has about 50,000 illicit drug users, of whom 20,000 are injecting drug users (IDUs), but actual numbers are likely higher. There were also around 75,000 people living with HIV and 5,100 AIDS-related deaths in 2005 (UNAIDS, 2006). HIV prevalence in Nepal is concentrated among IDUs, men who have sex with men, and women engaged in prostitution. HIV

⁸ The Nepal case study is based mostly on the "Nepal Core Package Final Report" (POLICY Project, 2006).

prevalence among IDUs indicates Nepal's move from low risk-low HIV prevalence (about 0.2–0.5 percent of the population) to a concentrated epidemic country. HIV prevalence generally follows drug trafficking routes where injecting drug use is increasing, compounded by high rates of STIs and the intersection of prostitution and injecting drug use. Extremely stigmatized, female IDUs are more hidden and, thus, at greater risk for HIV infection. HIV prevalence among street-based female prostitutes was 17 percent overall; but nearly 75 percent among those who inject drugs (New Era STD/AIDS Counseling and Testing Service and Family Health International, 2002). With conditions conducive to transmission among the general public, HIV prevalence could rise to 1–2 percent of Nepal's population within the next few years (Saidel et al., 2003). A generalized epidemic is possible in the next 5–10 years.

Drug use is illegal in Nepal and the government aims for “zero drug use.” However, there are no laws prohibiting the use of methadone or other opioid substitution treatment (UNAIDS and United Nations International Drug Control Program [UNDCP], 2000). The existence of several drug use and HIV policymaking and coordination bodies engenders confusion and hinders an efficient and effective response. Soon after the first AIDS case was diagnosed in the country and the National HIV/AIDS Policy was approved in 1995, the National AIDS Council (NAC) was established. The NAC developed the *National HIV/AIDS Strategy, 2002–2006* with guiding principles that include target group participation and multisectoral involvement. The National Center for AIDS and STD Control (NCASC) is the coordinating body for HIV. The Ministry of Home Affairs develops and implements policies to control illicit drug use while the Ministry of Health and Population addresses IDUs and HIV from a health perspective (UNAIDS and UNDCP, 2000). Political upheavals and frequent government changes further hamper efforts to address HIV and drug use. Although IDUs are at the center of the HIV epidemic, there are no dedicated government drug rehabilitation/treatment centers. Treatment is often provided by indigenous groups and NGOs and is primarily accessed by men. POLICY proposed an assistance package aimed at developing an advocacy network of recovering IDUs to provide an avenue for involving them in Nepal's policy process and address some of the confusion in the policy arena.

National Consultation. In July 2003, 50 participants nominated by drug rehabilitation centers in nine districts attended the first national IDU consultation. IDU leaders were trained to facilitate the meeting. Participants reported feeling valued for the first time as partners with skills and motivation to help others. After meeting among themselves, the IDUs accepted POLICY's proposal and requested that: a) two IDU coordinators, one male and one female (for gender balance) be selected from among them through an interview process to be responsible for organizing meetings, serving as secretariats, and training preparation; and b) an Advisory Group (AG) be constituted to coordinate network building and advocacy of their “project,” thereby claiming ownership for the entire effort.

Focus Group Discussions (FGDs). In the fall of 2003, AG members conducted 19 FGDs in six regions to collect information that could help improve understanding of the impact of HIV- and drug use-related stigma and discrimination, and ascertain drug users' needs and access, particularly with regard to harm reduction and treatment for drug addiction. Participants were current and former drug users, mostly males. A separate FGD was conducted for females. Being former IDUs themselves, the AG's involvement greatly facilitated the FGDs as they showed sensitivity and respect for participants' views and confidentiality. In general, IDUs stressed their need for training on public speaking, knowledge of drug- and HIV-related issues, capacity to work with IDUs, and management and proposal skills. Male IDUs highlighted the lack of access to drug treatment, especially outside of Kathmandu, lack of skills and education, rejection by family members and the community, low self-esteem, discrimination, harassment, isolation, and a lack of trust. While female IDUs identified similar concerns, they also stressed gender-specific discrimination: the misconception that all female IDUs support their drug habit through prostitution; discrimination against children of IDU mothers; and even discrimination from male IDUs.

National Leadership Training and Birth of Nepal's First IDU Network. FGD data were used in developing the National Leadership Training curriculum. The first National Leadership Training was held in Pokhara in February 2004 for 38 participants from all major regions. The training was organized, implemented, and facilitated by recovering IDUs, previously trained, with POLICY support. The training curriculum included the following: public speaking; basic HIV information; drug-related harm, relapse, and HIV; practical care and support to active, recovering, and relapsed drug users and those living with HIV; available HIV and drug user services; and basic facilitation skills. At closing, the AG and participants signed the “Pokhara Declaration” to encourage IDUs to stay unified and committed to create change. They formally named their alliance “Recovering Nepal” (RN).

In May 2005, RN was formally registered with the chief district office and social welfare council of His Majesty's Government of Nepal. RN's mission is to advocate for the rights of drug users, address stigma and discrimination, and ensure affordable and available treatment for drug users and people living with HIV. Nepal currently has approximately 3,000 recovering drug users, and most are directly or indirectly involved in RN's activities. RN developed by-laws and an organizational structure as well as its own newsletter and a website. By late 2005, RN had 64 formal members, including 11 executive board members, and four paid staff.

Advocacy and Results. In March 2004, RN conducted an advocacy workshop for 21 IDU participants, including AG members, who had all taken part in either the initial leadership training or its replication. The workshop aimed to provide basic advocacy skills, assess IDU resources and needs for advocacy, and prepare a six-month advocacy plan. A follow-up workshop led to a national advocacy plan that aimed to raise awareness on drug-related issues, HIV, and existing stigma and discrimination against IDUs and HIV-positive people; promote the allocation of funds to provide treatment, care, and support for IDUs and people living with HIV; and build a two-way support system network among the community and service providers to ensure affordable and available treatment, care, and support for male and female IDUs.

RN's advocacy activities included working with the media to raise awareness of stigma and discrimination against IDUs and people living with HIV. As 2005 ended, RN already had several policy-related achievements. As a result of RN's advocacy, the Global Fund Secretariat and the United Kingdom's Department for International Development (DFID) changed their policies to ensure that vulnerable groups are eligible to apply for grants without restrictions. RN's proposals were also included in the Bill on HIV/AIDS prevention, care, treatment, and support that is under consideration by the government. Moreover, the Ministry of Health and Population approved IDU participation in methadone policy and program formulation through IDU membership on the committee to draft the national strategy; membership on the Steering Committee on Substitution Therapy which reviews, monitors, and supports the ongoing program; and representation on the steering committee for risk reduction. RN will also be involved in support, counseling, and implementation of the Methadone Maintenance Program in five different regions.

Summary. RN demonstrated that drug users, if given the opportunity and appropriate assistance, can mobilize and engage meaningfully in policy and program development and implementation. Through RN, IDUs in Nepal have moved from being unorganized and marginalized into becoming a unified coalition that is now actively involved in policy formulation and implementation. RN has already had significant achievements and, in the process, IDUs developed strategic relationships among themselves and with policymakers, the media, donors, and HIV service and drug rehabilitation organizations. Nepal provides a feasible model focusing on capacity building to foster a thriving support and advocacy network for IDUs. One key element of network building and advocacy helped achieve various results: IDU ownership of the initiative right from the start and throughout the process, from network formation to training to advocacy implementation.



INDIA: White Ribbon Alliance Promotes Safe Motherhood⁹

The National Family Health Survey (1998/99) estimated India's total fertility rate (TFR) at 2.9 births per woman. Modern contraceptive use among currently married women was 42 percent, with sterilization accounting for three-fourths of contraceptive use. An estimated 16 percent of married couples had unmet need for family planning. Infant mortality was 66 per 1,000. More than 100,000 Indian women die in pregnancy and childbirth each year, among the highest levels in the world. Maternal and newborn mortality and morbidity levels in India are high because, in part, only 20 percent of pregnant women received all components of antenatal care, and the majority of births continue to take place at home with a large proportion attended by unskilled persons. Four out of 10 women reported symptoms of reproductive tract infections (RTIs). HIV prevalence, predominantly through heterosexual contact, is over 1 percent among antenatal (largely monogamous) women in some areas, raising concern about the rate of spread of HIV. Fifty percent of new infections occur in people below age 25 and for every 12 men infected, 10 women also test positive. UNAIDS estimates that India has 5.7 million people living with HIV, which is now the highest number for any country in the world. Adolescents (10–19 years of age) account for one fifth of the population and are in great need of information and services on sexual and reproductive health (United Nations Population Fund [UNFPA]/India, 2005). Today, twice as many Indian women as men are illiterate; girls are still less likely than boys to attend primary school.

The Global White Ribbon Alliance for Safe Motherhood (WRA) was formally launched in India in November 1999 to address the plight of mothers. The White Ribbon Alliance-India (WRAI) was established to improve maternal health as a critical means to building stronger families and communities in the country. To ensure action on several fronts, WRAI established four subcommittees focusing on different groups and activities: families and communities; advocacy with policymakers and opinion leaders; media and communication; and dissemination of best practices for safe motherhood. Since its establishment, WRAI actively collects and compiles data related to maternal mortality. Its activities include holding press conferences, meeting with government agencies (particularly those in the health sector), and organizing advocacy and awareness events throughout the country.

WRAI launched its national campaign, "Safe Motherhood is the Right of All Women" on April 7–11, 2004, in conjunction with National Safe Motherhood Day. WRAI members from all over India organized a series of programs to disseminate key messages through the media and a series of postcards to highlight international rights to safe pregnancy and delivery and to reinforce the theme that it is a social injustice for a woman to die during pregnancy and childbirth. On World Health Day in April 2005, the Prime Minister and other heads of state launched the *World Health Report 2005: Making Every Mother and Child Count* in India (World Health Organization [WHO], 2005). At WHO's request, WRAI organized the event and led advocacy efforts for countries in the region. WRAI prepared the messages, designed and produced advocacy materials, and mobilized celebrities to promote safe motherhood, in general, and World Health Day 2005, in particular.

Advocacy and MOH Actions. WRAI has been advocating for policy changes that will increase access to an effective referral system and emergency obstetric care (EmOC) throughout India. WRAI first conducted a workshop to compare WHO Midwifery Standards of Practice to Indian nursing standards and to identify gaps in skills. To follow up, WRAI presented a background paper on "Skilled Birth Attendants and the Need for Obstetric Care in Rural Areas" to the Indian government, donor agencies, professional bodies including the ob-gyn society, various NGOs, and civil society representatives in March 2003. The paper stressed the urgency of making EmOC accessible and also recommended that auxiliary nurse-

⁹ Based on information from the WRA newsletter and documents from WRAI.

midwives (ANMs) practice life saving skills, supported by adequate infrastructure and supplies, and supervised from a functioning primary healthcare referral system. WRAI has been involved in the development of “RCH II,” the official Reproductive and Child Health Program of the government.

In 2004, the Ministry of Health and Family Welfare invited WRAI to take the lead in developing evidence-based guidelines and protocols for the ministry’s essential package of maternal and child health services. These protocols are intended to enable healthcare providers at various levels to give high-quality care during pregnancy, delivery, and in the postpartum period, taking into account the needs of the mother and the newborn. WRAI was chosen because of its broad-based membership, knowledge, and reach at the local, subnational, and national levels in India, and ability to communicate and represent issues from the community to high-level decisionmakers. To initiate guidelines development, a small working group was formed that included WRAI members, the Federal Obstetric and Gynecological Society, Nursing Council of India, Trained Nurses Association of India, WHO, UNFPA, and United Nations Children’s Fund (UNICEF).

In April 2005, with the endorsement of India’s Secretary–Health and Family Welfare, guidelines for antenatal care and skilled attendance at birth by ANMs and lady health visitors were launched. Two related documents were also disseminated: guidelines for management of common obstetric complications by medical officers, and guidelines to operationalize 24-hour functioning primary healthcare under RCH-II. Following this, the Ministry of Health and Family Welfare asked for WRAI’s assistance in taking these new guidelines to the implementation phase. WRAI’s current membership of 77 organizations at the national level and five state chapters represents healthcare providers and NGOs working in various communities. This collaboration is viewed as key to achieving significant results from the health facility to the household levels, through strong, integrated health systems at national and local levels.

Summary. WRAI—a broad alliance of national, state, and community groups—has been very successful in raising awareness among policymakers and the general public regarding maternal mortality and what people can do to reduce it. The alliance focuses on its primary issue of safe pregnancy and childbirth, uses common approaches, and has been particularly successful in organizing public events around a specific, significant day to promote its message. WRAI’s strong linkages with the national health ministry and the alliance’s wide membership and reach—especially providers at various healthcare levels—provide great potential for significant improvements in pregnancy and delivery care practices.



PHILIPPINES: Local Partnership for Contraceptive Independence¹⁰

Although declines have occurred, current fertility rates (3.5 children per woman) and population growth (2.4%) in the Philippines are high by international and Asian standards. Close to half of women in union use family planning, with 33 percent using modern methods while 16 percent rely on traditional methods. The demand for family planning remains high: 4 million women are using modern contraceptives, 2 million use traditional methods, while 2.5 million who want to delay or limit childbearing are not using any family planning method (Zosa-Feranil, 2004b, based on 2000 census and 2003 National Demographic and Health Survey). The country has a reputation of limited success in its population program compared with its neighboring countries (Raymundo, 2004).

¹⁰ This case study is based primarily on an unpublished brief prepared by Perez (2004) for the contraceptive security supplement of POLICY’s Advocacy Training Manual. Additional information provides the background and information on recent events.

Contraceptive self-reliance of the Philippine Population Program was first announced by the Secretary of the National Economic and Development Authority (national planning body) and chairman of the Board of the Population Commission (POPCOM, the lead agency for population policy and advocacy) in addressing the United Nations General Assembly in July 1999. For years, the Philippines relied on USAID for contraceptive supplies. In January 2000, the POPCOM Board launched the Contraceptive Independence Initiative (CII). POPCOM then estimated contraceptive requirements to reduce unmet need and the potential shortfall in supplies as USAID phased out its contraceptive donations. POPCOM and the Department of Health (DOH), the lead agency for family planning services, proposed to the Philippine Congress a budget line item for contraceptives in the DOH budget. An NGO network—Reproductive Health Advocacy Network (RHAN)—also advocated for contraceptive self-reliance because of concerns about limited choices for the population and potential adverse effects on the health of mothers and children. From 10 women’s groups originally, RHAN had expanded into 30 civil society groups. RHAN conducted awareness-raising activities about CII using various channels, including the media, targeted to reach public and sectoral leaders (Perez, 2004).

In mid-2000, Congress appropriated 76.5 million pesos (a little over US\$1.5 million) to the DOH budget for contraceptive procurement. However, the Estrada administration was ousted and Arroyo was installed as president in early 2001, resulting in the use of the appropriated funds for other purposes. The Arroyo administration, which rose to power with the help of the Catholic Church hierarchy, would not allow a national budget allocation to be used to purchase modern contraceptives. The president along with the Secretary of Health, however, declared that decentralization allows local governments to exercise discretion in deciding whether and how much to allocate for contraceptives (Llaguno, 2003).

Landmark Local Contraceptive Security Initiative. Changes in the national political environment gave an opportunity for a local champion of population and development policies to move toward contraceptive security. Provincial Governor Victor Agbayani of Pangasinan, the country’s largest province, held a dialogue with experts and provincial and municipal population program implementers to address the province’s unmet need for family planning. The governor had earlier signed an agreement with the Catholic Archdiocese and the DOH for the province to be a pilot area for a natural family planning project. But the governor and local partners also were concerned about the need to ensure a wide array of contraceptive choices for the population, particularly because declining supplies of modern contraceptives due to the USAID phaseout and the lack of national government spending for modern contraceptives would severely affect provincial social and economic development. There was also the potential for increases in unintended pregnancies, especially with recent data indicating the province’s high fertility rates and unmet need. Various groups responded by seeking and obtaining funding from USAID through POLICY for a pilot project on contraceptive self-reliance in the province.

Soon thereafter, a group of Pangasinan NGOs advocating for issues such as women’s health met with the governor and promised to support the contraceptive self-reliance initiative. The result was the formation of a network of 24 NGOs known as Advocates for Better Living in Pangasinan (ABLE-Pangasinan). Supported by POLICY in its expansion and advocacy capacity-building efforts, ABLE’s advocacy campaign started with ascertaining how local chief executives, legislators, and program stakeholders in eight municipalities and two cities viewed family planning. The advocates recognized that the first barrier to contraceptive self-reliance was weak political support from municipal and city mayors who deferred to the views of conservative Catholic bishops and priests regarding modern contraception. At the same time, ABLE invited the mayors’ wives to become members of the network. ABLE members also met with municipal budget officers to identify sources of funds for contraceptives. ABLE held dialogues with some of the most influential among the province’s municipal and city chief executives and persuaded local legislators to enact policies to support contraceptive self-reliance and ensure free family planning commodities for the poor. ABLE advocates also traveled to communities to meet with local gatekeepers,

including the elderly, *barangay* and village leaders, and elected officials, and with various groups including mothers and fathers, farmers, tricycle drivers, and adolescents.

After advocating for eight months in the face of severe budget constraints in the affected localities, ABLE, in partnership with the governor and population and family planning program implementers of local government units, persuaded seven municipal and two city mayors to allocate funds in their 2004 budgets for contraceptive procurement. All together, a total of approximately 1.5 million pesos (US\$38,000) was allocated. In addition, the governor approved a separate line item for contraceptive self-reliance in the Provincial Population Office budget. For the first time ever, Pangasinan allocated local resources for contraceptive procurement.

From Local to National Action. ABLE-Pangasinan's success in mobilizing local groups and achieving significant success toward contraceptive self-reliance at the provincial level helped pave the way for other local governments to emphasize their family planning programs (Llaguno, 2003), and the DOH to take action. The DOH took the first step in converging national and local efforts by creating the Technical Working Group on Contraceptive Self-Reliance (Administrative Order No. 161 of August 2003), composed of DOH officials and eventually expanding to include other program stakeholders, including those from the private sector and local governments.

Recent events drew attention once again to the need for contraceptive self-reliance. First, public surveys showed wide support for family planning. Second, several candidates who publicly supported family planning won in the 2004 national elections. Third, wide public attention on a Filipino driver held hostage by terrorists in Iraq pressured President Arroyo to pull Philippine forces out of Iraq. The media's extensive coverage of the driver's return to Manila focused on his need to support eight children, futile efforts to find a decent-paying job in the Philippines, and desperate move to work overseas—a common plight for many families. Prominent personalities asked what was happening to the country's family planning program. Fourth, legislators, civil society groups, the media, and business leaders used the results of the 2000 census and the 2003 National Demographic and Health Survey to emphasize that, amid a looming financial crisis, a rapidly growing population would compromise efforts to boost the nation's economy and global competitiveness. Legislators supportive of FP/RH proposed several bills in Congress. During Congress's review of the DOH budget, senators and congressmen emphasized the need for contraceptive funding. As a result, the national government allocated a budget line item to procure modern contraceptives in 2005 (as reported by various Philippine media in 2004–2005).

Summary. Advocacy networks are needed to keep family planning on the public agenda in a country like the Philippines where, despite the population's expressed desire for family planning to help achieve health and economic aspirations, stakeholders opposed to FP/RH exert significant sway on political leaders. The Philippine experience demonstrated that in the absence of strong political support at the national level, family planning can be championed locally and succeed—through a partnership between supportive local government officials and a civil society network, and by mobilizing to widen support for family planning among local officials, opinion leaders, and various sectors of the population. Their successes helped bring family planning once again to the attention of national government.



ROMANIA: Local Coalitions Influence National Contraceptive Security Policy Reform¹¹

Romania's transition, after the 1989 revolution ended decades of dictatorship and an inefficient socialist system, has been difficult. High poverty rates and deteriorating health infrastructure prevailed in the 1990s. The total population was 22 million in 2000, but is declining since fertility levels have been low for decades because, like Ukraine, the population long relied on abortion as a family planning method. Abortion complications in Romania accounted for half of maternal deaths, which ranked among the highest in Europe. Access to family planning was limited. As late as 2000, primarily urban-based family planning clinics were the main sources of family planning services. No policy was issued to remedy the situation despite the urgency.

Policymaking in Romania had been confined to high-level national officials without civil society involvement. Reproductive health NGOs consisted of one family planning service delivery NGO, one youth reproductive health information group, and an HIV organization—all based in Bucharest, but with branches or volunteers in selected districts. These NGOs along with women's groups, media leaders, and local project offices of international organizations comprised the national Reproductive Health Coalition that was formed in 1996. A major advocacy challenge emerged as the government decentralized and implemented health sector reform, including social health insurance. National coalition members from Cluj, Constanta, and Iasi¹² Districts (*judets*) conducted public events (e.g., forums, fairs, and caravans) in their home districts to promote the need to improve access to reproductive health services through health insurance and increased government funding. During the Constanta public forum, which was attended by Romania's First Lady, the Director of the District Health Authority made a toast to network members for making public health endeavors much easier. The public events, which were covered widely by the media, contributed to the 1999 Government Order that included FP/RH services in the health insurance basic benefits package.

Policy dialogues within the MOH's Reproductive Health Policy Working Group soon focused on the declining stocks of public sector contraceptives (previously procured under an expiring health loan). In August 2000, the government approved, for the first time ever, an MOH budget line for contraceptives to be provided free to vulnerable groups (e.g., students, the unemployed, those with little or no income, and social welfare recipients). Implementation, however, was a problem: it was not clear whether the policy was working and if vulnerable groups were indeed receiving the subsidized contraceptives. To ensure focused efforts to address barriers to implementation, the MOH and local groups readily accepted a POLICY technical assistance package involving network building, research, advocacy, and policy dialogue.

Formation of District-level Reproductive Health Networks. Affiliates of the national reproductive health coalition brought together local NGOs (representing women, youth, HIV, education, labor, poverty, rights, faith-based organizations, and ethnic minorities), community groups, provider associations, and supportive government officials in Constanta, Iasi, and Cluj to form district coalitions that would advocate for reproductive health issues such as contraceptive security. Using POLICY small grants, the three district coalitions developed and implemented network-building plans that involved drafting mission statements and collaboration protocols, and forming coordinating councils. Three network members were also hired part time for six months by POLICY to facilitate network building.

¹¹ The case study is based on Zosa-Feranil (2004a).

¹² Also pilot areas of USAID's integrated women's health program, these three districts were chosen because they serve as regional centers. Moreover, events in these areas are often watched by national leaders.

Multisectoral dialogue occurred when the results of three studies regarding Romania's contraceptive security initiatives were presented during a roundtable in October 2001. Participants included the Director of the Budget and the Reproductive Health/Family Assistance Program of the MOH, district officials, representatives of provider associations and pharmaceutical companies, and members of the three new coalitions. Research results identified several policy barriers to contraceptive funding and distribution. Large segments of middle- and higher-income women obtained their contraceptives from government clinics. An assessment on the implementation of the new policies showed that low-income women were unaware of the new policies and also unlikely to receive free contraceptives because of limited supplies and difficulties in obtaining poverty certification. Participants recommended increased government funding for free contraceptives, improved access among the poor, and health insurance coverage of contraceptives. Following the roundtable, the coalitions met with Romanian experts to enhance network understanding of government financing and contraceptive security.

Coalition Launching and Advocacy. The district coalitions were launched through public events and community meetings to which district health authorities, insurance managers, and local groups were invited. The Cluj network also sponsored reproductive health sessions including contraceptive security on a local TV talk show that is also accessible nationally through cable. Coalition members also attended events sponsored by local governments. Local networks and district government officials often already knew each other professionally and/or personally even before the local networks launched their advocacy initiatives. During these events, coalition members spoke publicly and personally to district health authorities and insurance managers about the need to fund FP/RH services and supplies. To broaden support, the Iasi and Constanta coalitions involved NGO representatives from other districts areas.

As the MOH's Director of the Budget later relayed to the author, district public health officials and insurance managers requested central agencies to increase resources for contraceptives. Concerned about continuing a successful program in the succeeding years, the government approved annual budget laws containing budget line items for free contraceptives. The National Health Insurance House also approved coverage of generic formularies for oral contraceptives and injectables in the list of compensated drugs in 2002. In 2003, more contraceptive methods were added to the list (Zosa-Feranil, 2004a).

In December 2002, the Director of the Reproductive Health/Family Assistance unit of the MOH met with staff of USAID-funded POLICY and Frontiers projects to discuss whether there was a need to conduct operations research on poor women's access to contraceptives. It was agreed that POLICY would request the local networks to ascertain what was happening at the implementation level. The coordinator of the Constanta coalition (the largest of the three local coalitions) immediately responded by asking network members mostly from low-income households or ethnic minority groups to visit clinics in urban and semi-urban areas to inquire about how someone unemployed or with little income could receive free contraceptives. Network members were told by clinic workers to submit officially signed and notarized documents attesting to their limited income status. Members who proceeded to mayors' offices reported long lines and cumbersome requirements, such as property or asset declarations or field investigations to ascertain poverty claims. The network's report on the onerous certification requirements were relayed by POLICY to the MOH Director of Reproductive Health/Family Assistance who raised the findings with the Minister of Health and the Ministry of Finance. These events, in turn, led to approval on March 24, 2003, of Government Order 248 permitting self-certification of poverty status.

The coalitions also advocated for another issue: government funding for NGO involvement in public health initiatives, such as health promotion or community education. The coalitions' commitment to women's health and ability to mobilize community members greatly impressed the MOH Directors of the Budget and the Reproductive Health/Family Assistance Department. The coalitions worked with the Budget Director to discuss government funding mechanisms, in turn winning the Budget Director's support. They also met with the Reproductive Health/Family Assistance Director to draft criteria to

accredit NGOs implementing public health initiatives. The MOH official personally promoted the coalitions' advocacy issue to MOH leaders. In February 2003, the government approved norms for NGOs to receive government funds to implement national public health initiatives, particularly with regard to informing and mobilizing communities.

Sustainability Issues. The sustainability of reproductive health advocacy efforts by the three district coalitions is a concern. POLICY assistance to Romania ended in 2002. The networks had hoped that the government would soon provide funding for NGOs to be involved in public health efforts after the policy was approved. However, the policy has not been implemented. A new government administration took over and new leaders were appointed to the MOH. Once dynamic and expanding even into neighboring districts, the Iasi network was left leaderless when its active coordinator left for the United States in 2004 before structures for network sustainability could be established. The Cluj network ceased functioning entirely, as members of the smallest of the networks focused once again on their individual organizations' projects.

Only the Constanta coalition remains active up to the present. A likely reason for the network continuing is the network coordinator who readily tapped members' skills and resources, delegated responsibilities, and encouraged participatory decisionmaking and implementation early on in the network's development. Additionally, aside from always working in teams during various advocacy campaigns, Constanta network members also had close interpersonal relationships (e.g., helping members with financial problems to find part-time employment). The network coordinator actively sought and received grants from other international donors for the network, for example, to mark the 10-year anniversary of the 1995 International Conference on Women in Beijing. Although the grants were small, the entire network became involved in printing and disseminating a brochure containing the main points of the Program of Action of the Beijing Conference which Romania signed. Network members used the brochures to remind community groups about the low status of women in Romania and the country's commitments to the Program of Action. Even today, Constanta network leaders continue to identify challenges that require civil society mobilization not just in reproductive health, but also in policy environments with globalization, more recently using their own resources to sponsor dialogue with youth about what Romania's impending membership in the European Union means for young people.

Summary. Romania demonstrated that subnational coalitions can influence national policymaking, but coalitions must have the requisite organizational and technical skills as well as working partnerships with the government sector. Increasing competence likely helped nurture network members' commitment and ownership of reproductive health issues. The networks' effectiveness in undertaking social mobilization campaigns and in using every opportunity to promote reproductive health issues impressed local officials. Soon, local officials were the ones raising the networks' issues to national officials. Network responsiveness in providing feedback to policymakers also reinforced their access to the decisionmaking arena. Once MOH officials saw what the coalitions could do, these officials also became champions of the issues and the coalitions. Overall, Romanian advocacy networks show that shared leadership fosters both professional and personal linkages, and such mechanisms can unify and keep a network moving through advocacy events.



RUSSIAN FEDERATION: Regional Networks Impact Local Policy Change¹³

The Russian Federation has over 140 million inhabitants, but the population continues to decline, as life expectancy has been falling while fertility is below replacement level. Other reproductive health challenges include still high maternal mortality, limited use of modern methods to prevent unintended pregnancy, continued reliance on abortion as a family planning method especially among the young, early sexual activity yet limited adolescent health education and services, and high STI incidence rates (Ashford, 2003; WHO, 2001). These reproductive health indicators point to the need to increase awareness among national and local policymakers about the links among various reproductive health components as well as between successful reproductive health programs and the health of the population, especially youth. After years of stagnation, the economy is now expanding (World Bank, 2006), but the geographic expanse of the country is a major challenge, along with persisting political and social problems, and the need to ensure a more enabling environment for reproductive health policies and programs.

Under Russia's health sector reform and devolution, health policy and financing decisions were transferred to local governments. However, reproductive health is not a priority among national and local political leaders. There is a need to build political will to generate resources as well as allocate scarce public funds for effective reproductive healthcare programs. Compounding the problem is insufficient capacity and coordination among civil society groups to advocate effectively for relevant policy changes at national and local levels. Donors, including USAID, have been assisting local groups in working toward a more open democratic society at local, regional, and national levels, emphasizing partnerships with civil society (Jorgensen, 2004).

Federal Advocacy Network. In 1999, a group of NGOs, professional associations, and individuals were assisted by POLICY I to form the federal Advocacy Network for Reproductive Health to advocate for policies that promote access to high-quality FP/RH and maternal health services. The new network advocated for federal attention to FP/RH, particularly for services for those most in need following the cancellation of the Presidential Family Planning Program and the central procurement of contraceptive supplies. The network conducted a letter-writing campaign, published and disseminated the fact sheet "Improve Health through Contraceptive Use," conducted a roundtable with national policymakers titled "Reproductive Healthcare is an Investment in the Future," and trained media representatives on reproductive health issues through a series of "media breakfasts." The network also published a special edition of an academic journal, *Health Management*, with a focus on reproductive health and related health advocacy in the former Soviet Union. The edition, co-sponsored by the State Duma Commission on Population and Development, was presented at a December 2002 Duma hearing where a network member spoke in favor of national reproductive healthcare programs and greater NGO involvement in policy development.

The network's Coordinating Committee members conducted planning activities that culminated in a July 2003 advocacy strategy meeting. It formally adopted a charter, published a public relations brochure, issued its second newsletter edition on adolescent reproductive health, and created a web page housed on the USAID-funded Healthy Russia 2020 web portal. As the need for regional initiatives emerged with the advent of decentralization, the federal network expanded membership geographically and sectorally through the inclusion of more non-family planning-focused NGOs.

¹³ The Russia case study is based on Jorgensen (2004).

Regional Networking and Advocacy Capacity Building. In 2001, network members from various parts of Russia reported reproductive health policy advocacy successes in their regions. While regional network members took strategic and operational cues from the federal network's plans, regional members planned and conducted activities entirely on their own. At times they even initiated activities that were not identified during federal network meetings. At this time, USAID's strategy also moved toward more regional approaches. POLICY, in turn, focused on forming and strengthening regional advocacy networks.

POLICY designed and implemented a 10-day regional TOT on network building and advocacy in February 2002 with funding from CEDPA's Women's Leadership Program. Participants included NGO leaders from various regions in Russia.¹⁴ The TOT provided participants with an opportunity to design and deliver a one-day advocacy orientation to 14 Moscow-based NGOs and program managers from other USAID projects (that addressed HIV, education, disabled persons, orphans, legal rights advocacy, and environment). A condensed three-day TOT was also held in December 2002 for other network members and USAID partners unable to attend the February training. TOT participants subsequently reported that they had conducted around 110 workshops attended by more than 2,600 individuals and representatives of NGOs.

Following the February TOT, Russian participants used POLICY small grants to establish RH networks in their regions. By summer 2003, five new networks were formed in the Far East Region, in Altay Kray, and in the Tver, Tomsk, and Perm *oblasts*. Regional network coordinators then trained members in advocacy and built partnerships with public sector colleagues. A second round of small grants was provided for the networks to design and conduct local advocacy campaigns. Activities started with assessments of existing and proposed reproductive health policies and programs and the collection of data for advocacy in local areas. The review of current and draft policies affecting reproductive healthcare services in the regions led to opportunities for networks and public sector partners to dialogue on issues related to regional reproductive health policies and programs. Tools for assessing, developing, and analyzing policies and their implementation were also provided. Networks organized workshops on strategic planning, organizational development, and fundraising to foster sustainability. After the regional networks drafted strategic plans, two leaders from each of the five networks attended a workshop on monitoring and evaluation of strategic plans. In several cases, these leaders "echoed" monitoring and evaluation workshops for their own networks, thus continuing the downstream training pattern established with the TOT.

Network Outcomes and Results. Regional outcomes and results surpassed expectations. Organizationally, each network has a strategic plan and an established identity. Most networks have prepared a newsletter or promotional materials and expanded their memberships. Networks have identified training needs of members, which are being addressed. In terms of advocacy, each network has identified its own reproductive health issues, undertaken local research related to those issues, developed advocacy strategies, and created partnerships with public sector officials. Overall, the regional RH networks in Russia are determined to continue into the future. The networks have also made significant progress toward their advocacy objectives; some have already influenced several policy actions in their own regions, including the following:

- Access to free public transport for antenatal visits and discounts on vitamins and anemia medication for the rural poor in the Kozevnikovo area.
- A decree to increase screening and early diagnosis of reproductive health problems among adolescent men (issued by the Health and Education Departments of Barnaul City, November 2002).

¹⁴ Participants also included two members of the Ukrainian RH Network and two from Armenia and Uzbekistan.

- Approval to implement the program, “Reproductive Healthcare of Youth and Adolescents of Kozevnikovo Rayon” (issued by the Head of the Rayon Administration, January 2003).
- Approval of Tomsk Oblast Healthy Child 2003 Program which included key reproductive health components (passed by the Oblast State Duma and approved by the oblast governor, March 2003).
- Approval of the Interagency Program, “Reproductive Health of Youth and Teenagers of Barnaul for Years 2003–2006” (issued by the City Duma, June 2003).
- Issuance of five *Kray*-level decrees on youth, adolescent reproductive health, family planning, STI prevention, and healthy lifestyle skills (by the governor of Khabarovsk Kray, July 2002–November 2003).
- Approval of two policies for youth health and development in Tomsk (by the Head of Tomsk City Educational Department, September/October 2003).
- Approval of the Program “Reproductive Health of Solikamsk City Population for 2004–2007,” focusing on FP/RH education and services (by City Legislative Council in Perm Oblast, October 2003).

Summary. As Jorgensen (2004) summed up, Russia demonstrated that regional network formation and development can progress rapidly and soon achieve local reproductive health policy changes. For countries as large as Russia, or those in the process of devolving authority to regions, Russia presents a coalition model wherein members of a federal network formed independent oblast/local advocacy networks to influence local policymaking. This model may even be more effective than forming and developing a national network that would then reach out to different areas. From a donor perspective, the most important lesson regarding local advocacy networks was the value of conducting a TOT followed by small grants for TOT alumni to form, train, and lead networks. This approach, augmented with follow-up training workshops for network leaders who then transferred knowledge and skills to their respective networks, had a clear impact on the sense of ownership that fostered extensive advocacy activities and led to results.



TURKEY: Women’s Network for National Contraceptive Self-Reliance¹⁵

By the mid-1990s, Turkey had promulgated several progressive FP/RH policies. Its TFR was about 2.6 in 1998 while contraceptive prevalence approached 64 percent. Donors and other stakeholders, however, were concerned that government support had been sporadic and inconsistent, that a supportive policy environment did not always translate into concrete and sustainable programs and funding, and that FP/RH policy processes had been relatively closed to the meaningful participation of nongovernmental actors. Policymakers viewed NGOs as unorganized, technically weak, and ill-informed about policy matters, while NGOs perceived public sector officials as bureaucratic and out of touch with the people. A 1995 assessment indicated competition and lack of communication among Turkish NGOs, although the NGOs themselves wanted to change the situation. For decades, the family planning program relied on USAID contraceptive donations. As USAID/Turkey was phasing out, the Mission requested POLICY’s assistance in facilitating the formation of an FP/RH advocacy network that could help ensure continuation of Turkey’s FP/RH gains.

¹⁵ Based on Cardenas and Richiedei (2000). See also Baser et al. (2002).

Development and Launch of the Network. After ascertaining that several NGOs were interested in organizing and becoming policy advocates, POLICY served as a catalyst in the creation of Turkey's first NGO advocacy network, known as Kadın İçin Destek Olusturma Grubu (KIDOG) or NGO Advocacy Network for Women. In March 1996, representatives of 11 respected and successful NGOs representing family planning, women's health, human rights, women's legal rights, and education came together during a workshop to identify techniques for networking and articulating the steps needed for designing and implementing an advocacy campaign and strategy. The NGO representatives defined the network's mission as conducting activities to raise the status of women, and its goal was to elevate women's quality of life and social status in Turkey.

The NGO Forum held during the UN Habitat II Conference provided KIDOG with an opportunity to initiate advocacy efforts. KIDOG members worked together to attract the attention of policymakers. During the Forum, KIDOG showcased its work on women's issues through an exhibition booth, fora, and presentations. Members of the media covered KIDOG's activities during Habitat II and, thus, publicized the network's potential. POLICY and other USAID-supported projects strengthened the advocacy skills of KIDOG members through a series of skill-building workshops on advocacy and strategic planning. By the end of 1996, KIDOG was already designing and implementing various advocacy campaigns. KIDOG members also translated POLICY's advocacy training manual into Turkish and used it to train groups in advocacy. By so doing, KIDOG members gained confidence in their technical skills. From an initial 11 member organizations, KIDOG membership grew to 20 NGOs by 1999.

Advocacy and Results. KIDOG's most successful venture into advocacy came about in 1997, with USAID's plan for contraceptive phaseout by 2000, a plan that required Turkey to rely on its own resources to finance, procure, and target the distribution of contraceptive commodities. Without immediate and substantial funding, Turkey's contraceptive supply was estimated to last only six months, resulting in potentially devastating effects for the government, families, and individuals. The shortfall would seriously set back the country's progress in modern contraceptive use and signal the government's inability to improve the reproductive health status of Turkish women, an objective to which the government committed itself as a signatory to the ICPD Program of Action. Moreover, key stakeholders and donors were concerned that limited access to modern contraceptives among women and couples, particularly the poor and underserved, could lead to increases in unintended pregnancies, increasing illnesses among mothers and infants or even death in the absence of quality antenatal, delivery, and neonatal care.

POLICY earlier assisted the MOH in assessing the implications of the phaseout and forecasting the government's commodity and funding requirements. The MOH, however, could not mobilize government agencies to allocate sufficient funds for contraceptives for various reasons, including lack of political will, perceived shortfall of financial resources, and the absence of pressure from outside forces. Thus, USAID and POLICY proposed to the MOH to build support for contraceptive self-reliance by partnering with KIDOG. The MOH had some apprehensions with the proposal because Turkey's NGO sector was perceived as disorganized, composed of competing members, and technically weak. USAID and POLICY also met with KIDOG to discuss the need to support the MOH's contraceptive self-reliance initiative.

Significant dialogue took place before KIDOG took on the issue of contraceptive self-reliance. The organizations comprising KIDOG had diverse missions, structures, institutional cultures, and programmatic expertise, and there was a need to reemphasize reproductive health as a shared goal among KIDOG members. Network members went through a thoughtful and lengthy process of analyzing members' concerns and weighing the perceived advantages and risks accompanying the network's involvement in family planning issues. Some members felt that by agreeing, KIDOG was compromising its autonomy at a time when the network was trying to define its own organizational identity. Others argued that taking on the campaign would be indication that KIDOG was committed solely to

reproductive health issues and not committed to its broader goal of enhancing women's quality of life. One Coordinating Committee member felt that the FP/RH focus "alienated or distanced" certain member organizations, particularly those involved in education and legal rights.

As a Coordinating Committee member of the network later explained, the decision to commit to contraceptive self-reliance came about because of timing, feasibility, and resources (Cardenas and Richiede, 2000). Since access to information on national policy was then relatively closed to the NGO community in Turkey, KIDOG members saw advocating for contraceptive self-reliance as opening opportunities for the network to understand and monitor the policy environment, right at the time when the network was well on its way to undertake advocacy campaigns. The network also recognized that it did not have knowledge of planning, budgeting, and allocation issues within the MOH, in general, and on contraceptive financing and procurement, in particular.

Once KIDOG adopted the advocacy issue, however, network members invested significant time and effort on their campaign. They met with POLICY and MOH staff to understand contraceptive funding, procurement, and distribution in Turkey. KIDOG members then designed a two-pronged advocacy strategy to reach policymakers and generate media attention through very well-crafted advocacy messages. Network members targeted policymakers and called for immediate government budget support and procurement of contraceptive commodities for the public sector. Throughout each encounter with government officials, politicians, or the media, KIDOG members proved to be knowledgeable of their issue, supported with accurate and up-to-date data, and to have specific policy requests. The campaign yielded favorable media coverage that, together with members' formal and informal contacts, paved the way for a meeting between KIDOG leaders and then-President Demirel. The meeting led President Demirel to order the MOH to mobilize funds for government procurement of contraceptives.

A follow-up KIDOG campaign focused on stimulating consumer demand for high-quality FP/RH services and encouraging decisionmakers to respond. KIDOG became involved in awareness-raising and advocacy activities targeted to clients, service providers, and policymakers at several clinics in Istanbul. These activities were designed to promote client demand for high-quality treatment and services; to spur collaboration with policymakers, service providers, and administrators to improve the quality of family planning services; and to influence the Maternal and Child Health/Family Planning Office of the MOH to operationalize quality of care through responsive protocols and regulations. As described by Dr. Rifat Köse, head of the General Directorate of Maternal and Child Health/Family Planning in the MOH: "We are collaborating and KIDOG is making my job easier."

With the closeout of the entire USAID country program in Turkey, POLICY assistance to KIDOG eventually ended. Without POLICY's technical and financial assistance, the KIDOG network became inactive, as constituent organizations re-focused on their own institutional concerns, at times even competing for certain funding opportunities and projects.

Summary. KIDOG contributed to significant changes in the FP/RH policy arena in Turkey. Through its successful contraceptive security advocacy campaign, KIDOG debunked the impression that NGOs are weak and disorganized. Supported by technical training and small grants from POLICY, KIDOG members invested considerable time and effort to plan and implement the advocacy campaign for contraceptive security, thereby emerging as a credible partner of the MOH. KIDOG, however, has become inactive after USAID and POLICY assistance ended. The challenge facing KIDOG, and all advocacy networks whether in Turkey or elsewhere, is to sustain early efforts and successes while overcoming barriers posed by financial constraints, changing policy players, and competing loyalties.



UKRAINE: National Network Expands Local Adoption and Funding of the National Program

In the throes of an “acute demographic crisis,” Ukraine’s population shrank from 51 million in 1993 to 48 million in 2004, due to falling birth rates (TFR of 1.8 in 1991 to 1.2 at present), low life expectancy, and out-migration. In contrast, other developed economies have low fertility rates, but high life expectancy that has helped curb de-population. Other factors contributing to Ukraine’s fertility decline are the economic and social instability affecting nearly all segments of society and induced abortion persisting as a method of fertility control. The 1999 Ukraine Reproductive Health Survey showed that Ukrainians hold negative opinions about abortions and women want alternatives. Nonetheless, numerous reproductive health problems exist: limited up-to-date health and family planning information and services, poor women’s health leading to childbirth complications and maternal and fetal/infant losses, and increasing prevalence of STIs and HIV. Until 1998, the policy environment for reproductive health was unsupportive and policymaking was confined to high-level officials. Things started to change in 1999, when a multisectoral Policy Development Group (PDG) was formed by the MOH, with POLICY support. The PDG soon drafted the National Reproductive Health Plan (NRHP), which was approved by the President in 2001.¹⁶

Formation of First-ever National Reproductive Health Network. A September 2000 network-building workshop brought together 40 individuals and representatives of seven NGOs actively working on gender, youth, patients’ rights, and education, along with private medical institutions, trade groups, and pharmaceutical companies. Participants gathered together to discuss the need to organize a network for reproductive health advocacy to enable members to participate in the political process at the national and oblast levels. The workshop agenda included sessions aimed at facilitating network formation, based on POLICY’s advocacy training manual. Workshop participants saw membership in advocacy networks overall as advantageous because of the following: equality and common political power; sharing of common resources, interests, information, experiences, and practices; coordination, sustainability, and the involvement of target groups and partners; joint programs; creation of positive image; and influencing public opinion and legislation. The Ukrainian participants also stressed the following in establishing and maintaining advocacy networks: volunteerism; clear goals, priorities, strategies, and tasks; establishment of an initiative group and a coordination center; decisionmaking; planning; and financial support (Truhan et al., 2000).

Workshop participants, finding commonality between their own organizational objectives and improving reproductive health as a goal, formed the Ukrainian Reproductive Health Network (URHN). During the next few months, the members met regularly to establish the network’s coordination and communication structures. They also drafted the network’s mission statement. Even at this early stage, network members remarked on their working closely as a team, and the open exchange of information and experiences among them. The network’s goal, mission statement, organizational structures, and guiding principles were articulated in what eventually became known as the URHN Charter, adopted in 2001. Although URHN includes members with both government and NGO affiliations (just like those in Romania and Russia), URHN’s charter stresses the active involvement of NGOs and volunteers in furthering the network’s goal. Considering the challenges facing an entirely new network, a local expert who became deputy of POLICY/Ukraine also served as the project’s advocacy coordinator to facilitate the transfer of technical and organizational skills to URHN.

Advocacy for the National Reproductive Health Program and Related Policies. URHN selected an issue related to the network’s goal: local adoption and funding of the newly approved NRHP (Truhan et

¹⁶ Based on internal POLICY/Ukraine quarterly and semi-annual reports prepared by Philippa Lawson.

al., 2000). In so doing, network members agreed on the importance of partnering with the government through the PDG. An advocacy workshop was held in 2001 to provide network members with technical knowledge for the advocacy campaign. During the workshop, network members reviewed the URHN Charter and then reported on how they already applied their advocacy skills and knowledge in their own oblasts (districts). Early accomplishments included members presenting the NRHP in city administration meetings and preparing reproductive health fact sheets to advocate for local adoption/implementation of the NRHP. After discussions on national and local policy and financing processes, URHN soon came out with its plan to advocate for the NRHP.

To publicize its mission and its unique identity, members developed a brochure that highlighted URHN's advocacy campaign for the NRHP and was printed and distributed widely using members' own resources. A URHN member also produced a video that was used to advocate for reproductive health funding in the Odessa City health budget for 2003. The video was also shown on local television stations.

In 2001, the PDG requested URHN assistance in PDG's efforts to remove operational barriers to reproductive health access. In response, URHN created a national directory of NGOs working in reproductive health to facilitate linkages and collaboration between NGOs and government sectors, particularly for awareness-raising events in several oblasts. The PDG's draft "Reproductive Health Policy Guide," disseminated to all oblasts and ministries during a multisectoral workshop in May 2004 included a discussion on the importance of working collaboratively with NGOs and their role according to the new Civil Code.

While advocating for the NRHP, URHN expanded its advocacy plan to include efforts to address barriers to safe motherhood, contraceptive security, and youth access to reproductive health services. URHN's activities included facilitating dialogue with the Ministry of Education and the MOH on improving reproductive health education for the youth and involving NGOs in shaping public opinion on safe motherhood. On March 29, 2002, the Cabinet of Ministers approved the "Safe Motherhood Concept" (Directive No. 161-P) to reduce maternal and infant mortality by improving access to high-quality FP/RH information and services, including reproductive health education for youth. URHN worked closely with the MOH in developing the concept. In February 2004, the Ministry of Education increased classroom sessions devoted to healthy lifestyles, including reproductive health education, from 30 minutes to one hour per week. Under the new initiative, related reproductive health issues were integrated into other courses.

Strengthening Local Adoption and Funding of the NRHP. Since launching their national and local advocacy initiatives, URHN members have participated in national PDG meetings, and in subnational and sectoral working groups to develop local reproductive health programs leading to several local policy decisions. URHN's advocacy at an official public hearing led two representatives of churches in Lviv to sign a resolution supporting the implementation of the local reproductive health program—an unprecedented endorsement of the NRHP. In Makeevka, a URHN member ("Health of Nation" NGO) directly influenced decisions aimed at improving access to reproductive health services, including: (1) an order issued by the administration of 19 mining companies allowing pregnant women to visit doctors during working hours without suffering any wage losses (in November 2004); (2) approval of "The Health of Women and Children of Makeevka City for 2006–2010" program which included a budget allocation for the youth program (in November 2005); (3) a city budget allocation for the development and printing of IEC information packets on FP/RH issues for young adults; and (4) an order of the city administration approving NGO implementation of youth IEC campaigns in 2006 under the umbrella of the city local self-governing program (December 2005). As a result of URHN's advocacy, the Kremenchug city administration issued an order in 2003 to create local coordinating boards to coordinate and monitor the implementation of the NRHP. A URHN member in Kremenchug, ("Poryatunok" NGO)

also advocated for improved access to adolescent reproductive health information and services. In late 2004, the city administration ordered the opening of a youth center in 2005 with funding from the city budget.

Expanding Civil Society Involvement in HIV Policymaking. URHN established a model for effective advocacy and participatory policymaking in Ukraine. In May 2005, Ukraine created the National Coordination Council to improve the coordination of national and oblast HIV prevention and treatment programs. Activities of the national council involved approval of terms of reference for Oblast AIDS Coordination Councils, which were prepared in consultation with oblasts. The terms recommend that oblast councils include NGOs and people living with HIV.

Summary. Ukraine demonstrated that a national RH network can develop rapidly, even in countries in Eastern Europe or the former Soviet Union where policies were formerly decided by central authorities without any civil society participation. The strong commitment of URHN members and their willingness to volunteer personal time and resources made the Ukrainian network coalesce quickly. Their personal commitment and efforts to draw attention to URHN and its reproductive health goals gave the network a distinct identity early on. URHN's partnership with PDG was also important, contributing significantly to its rapid maturity, as well as its achievements. The PDG quickly tapped URHN to build local ownership of the NRHP, while URHN's involvement in national PDG meetings strengthened URHN's national and local credibility and, more importantly, fostered civil society participation in policymaking, a previously closed process. Ukraine demonstrates what networks in other countries have shown: partnership with supportive government leaders can help networks succeed.



GUATEMALA: Sustained Advocacy Coalitions Broaden Reproductive Health Policy Reform¹⁷

Despite persisting high maternal and infant mortality levels among its rural, indigenous populations in the 1980s and 1990s, Guatemala was one of the least supportive countries in the world of FP/RH services. Decades of civil war and violence severely constrained access to social services. Things started changing in the mid-1990s after the war ended, when civil society organizations and supportive parliamentarians and government officials urged greater attention to the FP/RH needs of the population. Advocates, led by women's groups and indigenous organizations, used Guatemala's 1996 Peace Accord commitments to health and gender to amend the public health law and enact a law to dignify women. Subsequent advocacy campaigns of coalitions led to more policy actions.

Coalitions for the National Reproductive Health Program. President Portillo's Cabinet that took office in 2000 included a supportive Minister of Health who aligned himself with women's groups by launching the National Reproductive Health Program (NRHP). An advocacy campaign conducted by the Guatemala Women's Physician Association (AGMM) culminated in a broad multisectoral alliance of NGOs and opinion leaders issuing a joint press release in February 2001 in support of the NRHP. In September 2001, Congress enacted the Law of Social Development that affirmed people's right to accurate information and to decide the number and spacing of their children. To avoid a potential presidential veto, REMUPAZ (the women's network for peace), AGMM, and the Guatemalan Association of Gynecology and Obstetrics (AGOG) organized an advocacy campaign that helped ensure that the president signed the law and the executive branch issued the Social Development Population Policy in April 2002.

¹⁷ Based on POLICY/Guatemala reports prepared by Lucia Merino.

In October 2002, civil society organizations led by REMUPAZ, AGMM, AGOG, and the Medical College issued a joint press release urging Congress and the Ministry of Finance to increase health resources, including for the FP/RH program. The following month, Congress approved a health budget that was much higher than originally allocated for 2003. Congress declared that the increase was in response to the demands of professional associations and civil society groups.

Coalitions for Sustained Commitment to Reproductive Health. In 2003, a new president assumed office, with incoming officials including the Minister of Health declaring support for the NRHP. Such statements were clearly influenced by a broad civil society alliance consisting of REMUPAZ, AGMM, AGOG, the Coordinating Committee for Political Action on Health and Women’s Development (INSTANCIA Salud/Mujer), and Foro de Redes. The alliance was formed months before the November 2003 election to garner continued support for FP/RH between the outgoing and succeeding governments.

The alliance developed and implemented an electoral strategy that involved providing reproductive health informational materials to political parties, holding forums so that political parties could outline their reproductive health agendas, and working with the media to disseminate the alliance’s activities and the agendas of major political parties and candidates. The alliance’s efforts led major political parties, including the party that eventually won, to include reproductive health in party platforms presented before the election.

Despite statements in favor of FP/RH, the new administration did not immediately adopt a formal reproductive health policy or program. Hence, civil society networks INSTANCIA and REMUPAZ launched a campaign in January 2004 to advocate for a formal government declaration on reproductive health in the National Health Plan, 2004–2007, and increased financing for the health sector, including reproductive health. The networks used various information—FP/RH indicators and their implications on future populations (based on estimates generated through SPECTRUM projection models developed by POLICY), health sector and reproductive health funding, program cost analyses, and international agreements affecting FP/RH—to prepare presentations, a proposal for integrated women’s and children’s health, and a proposed budget for the NRHP.

Well-prepared network members held several meetings with the MOH, the Congressional Commissions for Health, Women, and Human Rights, and the Inter-Parliamentary Women’s Coalition in Congress where network representatives highlighted the poor status of women’s and children’s health in Guatemala and the need for improved FP/RH services. The networks then proceeded to present their policy and budget proposals. The contents of these presentations and the proposals were widely publicized.

The efforts of the two networks led to several policy responses. In June 2004, the Congress approved Legislative Decree 21–04, which allocates 15 percent of taxes levied on alcoholic beverages (approximately Q26 billion or US\$3.4 million) to reproductive health, child health, and alcoholism prevention programs. In November 2004, the Congressional Health Commission amended the 2005 National Budget by adding Q25 billion (US\$3.2 million) for the NRHP. In December 2004, the MOH published “Basic Guidelines and Health Policy, 2004–2008” with objectives including the reduction of neonatal and maternal mortality levels and unmet need for family planning. In June 2005, the Institute for Social Security (IGSS) agreed to reinstate FP/RH services as part of health services provided to postpartum women by its health insurance affiliates.

Summary. Advocacy coalitions for FP/RH are fairly recent in Guatemala, but this case study shows that networks have directly influenced high-level reproductive health policy and financing reforms in the last 10 years. It is worth noting that not just one, but several networks and coalitions were involved in advocacy initiatives. Strong commitment among the allied groups, focus on a single issue each time, and use of a unified, well-tested strategy are major reasons for the successes of these coalitions. These

coalitions made maximum use of data and media coverage in undertaking advocacy events and forums with decisionmakers from the legislative and executive branches of government. The phrase “keeping an eye on the ball” truly applies to Guatemalan coalitions for reproductive health: they did not stop after achieving one or two policy changes, but kept vigilant about other challenges to achievement of their reproductive health goals, from one presidential administration to another.



PERU: Networks for Civil Society Representation in National Policymaking and Local Monitoring and Mediation¹⁸

The population of Peru faces numerous challenges including high levels of poverty, fertility, and infant and maternal mortality, particularly in rural areas and among marginalized groups. Although favorable population policies were approved in the late 1970s and 1980s, few were implemented and most family planning initiatives were undertaken by NGOs. Fujimori’s election as president in 1990 initiated a period of strong government support for FP/RH. In 1995, Congress legalized voluntary surgical sterilization (VSC) and the MOH began offering free family planning services. However, in 1997, the national family planning program was criticized for stressing targets rather than quality of services and client rights. Civil society organizations and the Catholic Church accused the government of forcing low-income and rural women to undergo sterilization, causing serious health problems and user rights violations. As recommended by the Ombudsman, the MOH consulted with public and private institutions and modified national family planning norms, including VSC procedures, in February 1998.

Toledo’s election in 2001 brought in a conservative government with key executive and legislative officials who opposed the family planning program. During 2001–2003, the MOH approved strategies to reduce maternal mortality without mentioning family planning as a means to reduce unintended pregnancies (POLICY Project, 2005). A basic health insurance mechanism was approved, but did not cover family planning supplies. The Health Policy Guidelines, 2002–2012, and Basic Elements for the 2001–2006 Strategic Plan set priorities for mother and child care, but made no commitment for family planning or HIV. Congressional/MOH committee reports about VSC abuses during the 1990s failed to mention measures taken to prevent abuses. An ombudsman report in 2002 cited numerous barriers to FP/RH access within the MOH service delivery system.

Government actions in 2002, however, opened opportunities for civil society involvement in health policymaking. The MOH approved Health Policy Guidelines for decentralization and the formation of the National Health Council comprising government and civil society representatives to formulate and coordinate health policies and programs. Two umbrella organizations—the National Network for the Promotion of Women (RNPM), a prominent nationwide network of women’s groups, and ForoSalud, a civil society-led coalition—played key roles in using these actions to help improve the FP/RH policy environment at the local and national levels.

RNPM—Women’s Network for Civil Surveillance. Sparked by the need to improve women’s access to health services and following the uproar about targets, the RNPM began forming Citizen Surveillance Committees (CSCs) in 1999 to assess the quality of FP/RH services received by clients and to monitor provider compliance with national family planning norms. Local CSCs were actively supported through RNPM’s regional branches. POLICY provided technical assistance to these regional branches in undertaking training workshops; supporting policy dialogue to solicit feedback from the public; expanding RNPM to the provincial level; and forming and assisting provincial-level CSCs. The RNPM and CSCs were also involved in monitoring compliance of the Tiahrt Amendment in Peru.

¹⁸ Based on POLICY/Peru reports prepared by Patricia Mostajo and network reports prepared by Edita Herrera.

Under Peru's health sector reform, health planning and budgeting are being devolved to regions and municipalities and to involve civil society groups. CSCs have, in turn, played key roles in local decisionmaking and funding processes. The Tomayquichua CSC, formed in June 2003 as part of RNPM's expansion strategy, successfully championed funding for maternal health in February 2004. This happened when CSC members were invited by municipal authorities to participate in a council meeting to discuss the local budget. During the meeting, the CSC advocated for maternal health and, in response, the council approved funds to purchase oxygen equipment to be used for obstetric emergencies in the health center.

Local CSCs were such visible and effective oversight mechanisms that a congressman sent a proposal to Congress in November 2001 recommending a legally recognized role for CSCs to ensure access and quality in health service delivery.¹⁹ The CSC concept has also been adopted by other NGOs. In April 2002, the NGO Transparencia, which monitors democratic processes and the use of public resources in Peru, developed the "Surveillance as a Mechanism of Citizen Participation" manual based on methodologies developed, tested, and refined by RNPM since 1999 through forming, strengthening, and supporting CSCs. This manual is being used by civil society and grassroots organizations to monitor public management and resource use at the municipal level.

ForoSalud Coalition for Health Policy and Planning. On August 22–24, 2002, civil society NGOs and networks, including RNPM, agreed to form a single health coalition called "ForoSalud" during the First National Conference on Health. This was the culmination of a dialogue on health policies among 10 NGOs and individual experts that was facilitated by the Consortium of Economic and Social Research (CIES) with POLICY assistance. The following month, ForoSalud was elected to represent civil society on the National Health Council, a multisectoral body that would analyze the health sector and formulate national health policies and plans, establish the country's health priorities, and promote coordination among members and with other sectors. As such, ForoSalud became the primary mechanism for citizens to participate in Peru's health policymaking processes.

Following its formation in Lima and recognition by the MOH as civil society representative in the Council, ForoSalud created regional ForoSaluds in Ayacucho, La Libertad, Junin, San Martin, and Ucayali to consolidate civil society inputs into decentralized health reform initiatives. The regional coalitions have been going through organizational meetings, preparing regional workplans, undertaking training workshops in policy diagnosis, and constituting thematic working groups. With ForoSalud coalitions promoting evidence-based health policy dialogue and action, local health authorities have increasingly recognized ForoSalud's contributions to health policy formulation and planning. In mid-2004, ForoSaluds were called upon by Regional Health Councils in La Libertad, San Martin, and Ucayali to participate in technical commissions on communications and regional health accounts. A situation analysis prepared by the ForoSalud catalyst group in San Martin was included in the Regional Health Plan. The ForoSalud catalyst group in Junin was elected to the Regional Health Council as the civil society representative in May 2004.

Networking to Promote and Protect Patients' Rights. In 2002, the government approved national policies intended to protect users' rights to health services and to resolve patients' complaints. These national policies, however, were formulated without civil society involvement. There was also the concern about limited knowledge among the population about patients' rights. Thus, Centers for the Prevention and Resolution of Conflicts in Health (CEPRECs) were established through the Association of Public Health Law to promote patient rights and to address patients' complaints through negotiation and conflict resolution. Various networks, including ForoSaluds, are now working with these centers. In

¹⁹ Congressional action on this proposal is still forthcoming.

October 2004, La Libertad ForoSalud's document on "Duties and Rights in Health" helped pave the way for authorities of the leading hospital in the regional capital of Trujillo to invite a CEPREC representative to present alternative mechanisms for conflict resolution. As a result, the hospital created an office to improve the hospital's quality of care and relationships with civil society.

In January 2005, the Pucallpa CEPREC conducted a workshop for local media professionals who subsequently decided to form a network for journalists reporting on health and human rights issues. The journalists' network has since prepared and disseminated through local radio and TV media spots designed to raise public awareness and mobilize opinion on the importance of promoting and protecting health user rights.

HIV Networks. As structures for improved civil society participation in FP/RH policy processes were established, nongovernmental and government groups also focused on HIV, including Colectivo por la Vida and Peruanos Positivos, a network of people living with HIV. Press conferences and advocacy workshops, conducted by Colectivo por la Vida between October and December 2003, served as the impetus for forming eight new regional networks composed of HIV-positive groups and other civil society organizations in Chimbote, Cusco, Huancayo, Ica, Iquitos, Piura, Pucallpa, and Trujillo in May 2004. The networks focus on improving the quality of life of people living with HIV and raising awareness about HIV and its prevention.

Peru's National Congress approved the final revision of Article 7 of the current AIDS Law (CONTRASIDA) in May 2004. First passed in 1996, CONTRASIDA was outdated as it did not adequately reflect or respond to the needs and rights of HIV-positive people, given new treatment options and human rights advances in the area of HIV. Recognizing this shortcoming, Colectivo por la Vida tapped POLICY assistance in drafting a proposal to modify Article 7 of CONTRASIDA. Prepared by the network's legislative committee, the proposed changes included language on non-discrimination, provision of free services and medication for opportunistic infections for people living with HIV, and the need for monitoring, pre- and post-test counseling, rehabilitation, prevention, and antiretroviral treatment. To mobilize support for its proposal, Colectivo's media committee made a presentation to Congress and conducted press conferences and presentations on radio and TV. Local network members also advocated to local congressmen to support Colectivo's proposal. These concerted efforts led the Congress to approve Colectivo's proposed modifications in January 2004. During the approval process, however, the Health Commission inserted language into the bill that mandated testing for pregnant women. Colectivo worked closely with the MOH to advocate for the elimination of the mandatory testing requirement. While Congress approved and enacted Colectivo's language on non-discrimination and provision of free services, it also imposed mandatory testing for pregnant women, likely to be an issue for future advocacy initiatives.

Summary. Despite numerous barriers affecting Peru's FP/RH policies and programs, civil society networks have been innovative in using decentralization as an opportunity to improve access to quality FP/RH services. RNPM formed and supported local surveillance teams to monitor compliance of national reproductive health norms. NGOs formed the ForoSalud coalition to represent civil society in the National Health Council, and then formed local coalitions to influence local health policy and planning. Indeed, structures for civil society participation in promoting, monitoring, and mediating health rights are gradually being adopted. HIV coalitions are also making inroads in promoting involvement of HIV-positive people in national policymaking and in forming local networks to address local challenges. Peru's networks clearly demonstrate the potential of decentralized settings in neutralizing limited support for FP/RH at the national level. They also provide models for active civil society participation in monitoring policy implementation and in serving as mechanisms for feedback to help ensure timely policy action.

ANALYSIS AND SYNTHESIS

The foregoing case studies of advocacy networks in selected countries were brief yet illustrate what networks did in the area of FP/RH, HIV, and maternal health and, most significantly, what they have achieved. Overall, specific factors made advocacy networks effective: commitment to a shared goal/mission; commitment to a unifying issue; implementation of a common strategy; technical and organizational capabilities; inclusiveness and representation; and public sector engagement. Country experiences also indicate that many of these factors are interrelated, with organizational and technical competence underlying most of these factors. The case studies also provided a deeper understanding of how certain factors played out across different countries, or even within a country, and which factors appeared to make the most difference.

Each of these key factors is discussed in more detail below. The analysis of each factor points to common experiences among networks in different countries, as well as adaptations or innovations undertaken by networks that made a specific factor help a network move forward or achieve results. The analysis ends with observations on which factors made certain networks sustain their advocacy activities even after POLICY's technical assistance ended.

A Shared Goal/Mission

All networks and coalitions supported by POLICY worked or continue to work toward goals to improve access to FP/RH, maternal health, and/or HIV services. The case studies point to the following factors as important elements that helped them reach a shared goal or mission.

Existing women's networks with reproductive health activities. While new reproductive health advocacy networks needed to be formed in many countries in Africa, Asia, and Eastern Europe, several national networks and alliances, particularly women's networks, were actively operating in **Guatemala** and **Peru** when POLICY began in 1995. This is not surprising considering the long history of activism and people's movements in Latin America. Moreover, the women's networks that led reproductive health advocacy initiatives in these two countries had already been involved in past efforts to promote women's health and were thus ready to take on reproductive health issues and build commitment within their respective organizations and among allied groups to ensure that reproductive health goals were shared and pursued.

Involvement of existing FP/RH NGOs. Most countries all over the globe have organizations and individuals working to improve FP/RH. Family planning associations are among the leaders in such initiatives and many have actually been around for decades. Nearly all networks in 10 of the 11 countries showcased above included FP/RH NGOs as members, oftentimes leading efforts to ensure commitment to reproductive health as a shared goal. Some women's organizations were involved in many countries and are among the most dynamic in the NGO sector.

Shared goal among similar groups or individuals. The process of network formation and reaching consensus on a shared mission or goal may proceed faster when groups or individuals with common characteristics or concerns establish a dedicated network, for example, a network of people living with HIV. Recovering IDUs in **Nepal** moved rapidly from being unorganized and marginalized into becoming unified to form their network, easily coalescing around their shared mission of improving access to services to support recovery and ensure their full and meaningful participation in society.

Fostering reproductive health awareness among diverse groups. Collective recognition of reproductive health challenges and their impacts on health and other socioeconomic concerns can unify different types of organizations. As members of **Ukraine’s** URHN pointed out, it was the commonality of reproductive health as a goal that brought them together, despite their diverse backgrounds, to become a single, distinct coalition that rapidly developed and soon achieved numerous results. Shared recognition of the lack of supportive reproductive health policies and programs galvanized women’s networks, indigenous groups, and professional organizations in **Guatemala** to form an alliance or coalition and advocate for government support to national reproductive health policies and programs.

The importance of developing or revisiting reproductive health as a shared goal or mission becomes paramount for networks composed of organizations that are not primarily family planning- or reproductive health-oriented. It took some time for **Turkey’s** KIDOG network to decide whether to take on the issue of contraceptive self-reliance. KIDOG members represented three different fields—health, education, and legal rights—linked to one another by their common overall goal: to elevate women’s quality of life and social status. Some members were concerned that their reproductive health campaign diverted them from their focus on women. In such instances, network members needed to be reminded that reproductive health is a main component as well as a determinant of women’s quality of life. This central theme about reproductive health should be taken more seriously in considering the sustainability of networks.

A Unifying Issue

Certain elements helped make networks unify around an issue. The criteria that networks often used in selecting an advocacy issue include the extent to which an issue widely affects many people, its potential for real change in people’s lives, consistency with the network’s goal and mission, and prospects for building alliances and grassroots leadership.²⁰ Issue selection often occurred during an advocacy workshop where network members considered various problems and policy actions before collectively deciding on one particular issue.

Commonality with organizational goal/mission. Most networks in the foregoing case studies selected advocacy issues that fell within broad frameworks defined by their goals. **Ukraine’s** URHN selected local adoption and funding of the newly approved National Reproductive Health Plan (NRHP) as its advocacy issue mainly because the goals and objectives set by the government in the NRHP were similar to those of the network. A URHN member described the main reason why the network succeeded: “The mission of URHN is similar to the mission of many URHN NGOs.” Consistency between URHN’s goal and advocacy issue further strengthened members’ commitment to espouse the issue not just nationally but also locally. The members of **Nepal’s** Recovering Nepal (RN) network chose stigma and discrimination against IDUs as a continuing advocacy issue considering members’ common experiences and the potential to effect real changes in the lives of IDUs through supportive programs.

Pressure arising from recent events or potential actions. Urgent developments such as a drastic budget cutback or the likelihood of a negative policy action can spur different groups to unite and focus on a specific issue. After years of governments unsupportive of FP/RH in **Guatemala**, alliances of networks and associations were temporarily established during the last 10 years to advocate for FP/RH each time there was a perceived threat or potential policy action. In **Turkey** and the **Philippines**, the potential

²⁰ *Networking for Policy Change: An Advocacy Training Manual* (POLICY Project, 1999) provides a checklist for choosing an advocacy issue, using criteria that include whether the issue is consistent with the network’s values and mission, widely affects many people, responds to the community’s expressed needs, and forms a basis to build alliances and grassroots leadership.

impact on women and families of limited government action to mobilize resources for contraceptives in the face of the phaseout of USAID donations mobilized networks to advocate for contraceptive security.

Reunifying through a new approach to a continuing challenge. New perspectives or approaches regarding an existing or continuing challenge can also help renew commitment to an existing issue and reinvigorate past advocacy efforts. For example, members of four district RH networks in **Ghana** who participated in the Regional TOT Workshop in Accra in May 2003 became so motivated that they formed a mini-network, the Policy Champions Group, to reposition family planning in their country considering that FP/RH problems persist.

Expectation of potential benefits. One network agreed to be involved in advocacy for a specific issue because of perceived potential benefits that members would gain. The KIDOG network in **Turkey** committed to contraceptive self-reliance because involvement on a new issue would provide the network with opportunities to access data and training on the issue, skills to analyze the policy environment, and resources through USAID and POLICY that would further hone members' technical expertise.

Implementation of a Common Strategy

Joint planning and implementation of a common strategy propelled networks to succeed in the 11 focus countries. Based on the networks' actual experiences, "common strategy" can be defined in two ways: as a unified strategy implemented by the various members of a network or coalition; or as a standard, well-tested, successful approach used for various advocacy campaigns by a single network or by different networks.

A Unified Strategy. The process employed by newly formed RH networks in various countries was similar: each network developed and implemented a common strategy to establish their new alliance. In addressing a chosen advocacy issue, the constituents of a network worked together to design and implement a strategy for their advocacy campaign.

The three **Romania** district coalitions went through a somewhat similar process in forming their own coalitions. Formed around the same time, the three coalitions coordinated in designing and implementing network-building plans. Constant communication among coalition leaders led the three coalitions to agree on the same goal and to jointly develop collaboration protocols. The strategies they utilized in advocating for local and national contraceptive security were also similar: coalition members held or attended public events where they spoke publicly and personally to district health authorities and insurance managers about the large unmet need for FP/RH services and supplies. These district public health officials, in turn, relayed the need for contraceptive resources to appropriate MOH and health insurance authorities.

The **Ghana** case study showed that the members of a network can unify around a strategy even if it was originally conceived by organizations outside the network—whether a government or a donor—as long as time and effort are invested in building ownership of the goal or issue. As the country decentralized, the National Population Council (NPC) developed a strategy to encourage the formation of district networks as mechanisms to consolidate civil society participation and foster public-NGO collaboration in population/reproductive health policy and program development. Once convinced of the initiative, the new district networks took ownership of the national initiative and conducted their own local advocacy campaigns.

A Well-tested Formula. Certain networks used a common strategy for advocacy campaigns over time. The White Ribbon Alliances in **India** and in other countries have been particularly successful in organizing public events around a significant day—such as a national holiday, Women's Day, Human

Rights Day—to raise awareness among policymakers, providers, and the general public about the problem of maternal mortality and what people can do to reduce it. The strategy of focusing on events has been used in different areas within countries where White Ribbon Alliances exist (please refer to www.whiteribbonalliance.org). In **Guatemala**, a standard, successful strategy was used by different alliances and coalitions in a series of reproductive health advocacy campaigns. The basic, well-tested formula consisted of data-based presentations to raise awareness about the issues, dialogue with national legislative and cabinet-level decisionmakers to discuss proposed policy actions, and extensive media coverage to promote public support and decisionmakers' commitment to FP/RH initiatives.

Technical and Organizational Capabilities

Technical competence. The country case studies demonstrated what technical capabilities were important and how networks ably applied newly learned skills in combination with their own technical and organizational expertise to influence a wide range of policy processes.

- **Data-driven advocacy.** The advocacy experiences of several national, regional, and local RH networks illustrated that data can serve as a network's ticket to the formal policymaking arena and a major tool to influence policy action and enhance a network's image and technical leadership. Networks in **Ghana** and **Guatemala** used the results of projections from POLICY's computer models to highlight potential health and development impacts of government inaction or limited support for FP/RH. District networks also conducted baseline surveys or collected local data that were used to prepare area-specific IEC and advocacy messages (used in fact sheets, newsletters, and presentations to promote local support and funding for FP/RH and HIV programs). The district networks' awareness-raising campaigns became so popular that tribal chiefs would hold conclaves for the networks to present to other influential individuals in their village. The MOH of **Uganda** finally approved the country's first comprehensive adolescent health policy after the URHAN network presented the results of its survey of program managers from different government ministries indicating that the absence of an official policy constrained implementation of adolescent health programs.

In **Romania**, district network members ascertained that onerous certification requirements were being imposed on poor clinic clients in order to receive free contraceptives. The information provided the data that spurred the MOH to approve self-certification of poverty status. In the **Philippines**, the ABLE network of Pangasinan province used the results of a provincial survey to raise awareness among local decisionmakers and groups about the importance of contraceptive security. In **Nepal**, focus group discussions with IDUs that were facilitated by the RN network of recovering drug users provided in-depth data on stigma and discrimination that are being used in national IDU and HIV policy development and public information initiatives. Overall, the networks' use of data was a powerful tool in advocacy.

- **Capabilities to train and/or support others in network formation, advocacy, and policy analysis.** In **Peru**, three national RH networks are forming and training local advocacy groups. The national women's network known as RNPM formed, trained, and supports local citizen surveillance committees. The ForoSalud NGO consortium is providing policy analysis training to local ForoSaluds. The HIV network, Colectivo por la Vida, formed and trained eight local HIV advocacy networks. In **Russia**, after attending an advocacy TOT, members of the federal reproductive health advocacy network formed and trained networks in their own regions. The new networks, in turn, conducted extensive advocacy activities that led to several policy actions at the regional, oblast, or city levels. Similarly, the KIDOG network in **Turkey** became confident

about undertaking advocacy campaigns by translating POLICY's advocacy training manual and using it to train other groups.

- Competency in facilitating public-private partnerships in policymaking and implementation. Nearly all networks from the case studies presented above demonstrated skills in initiating or fostering collaboration between the government and the NGO sector. This observation is true for national-level NGO networks, particularly those in **Guatemala** and **Peru**, which have extensive track records of commitment to FP/RH as well as newly formed but technically capable local networks in selected areas in **Russia** and in a province in the **Philippines**. The case studies also reveal networks' technical expertise in fostering public-private collaboration for FP/RH in countries with a long history of democratic movements and activism such as **Guatemala**, **Peru**, and the **Philippines**, as well as in countries such as **Ukraine** and **Russia** where NGO-led activism is fairly recent. Indeed, various countries showcased how NGO-initiated collaboration between the public and private sectors can work, despite the sensitive issues sometimes surrounding FP/RH issues.

In **Turkey**, KIDOG's successful campaign for contraceptive security changed government officials' perception of the NGO sector as technically weak. MOH officials praised KIDOG's ability to approach other government ministries and also private sector NGOs, which the MOH could not easily do. KIDOG members also actively participated in MOH planning meetings to prepare the national strategic plan for women's and children's health.

Public-private partnerships in policy processes can become so valuable that over time they become a standard or usual course of action. Three examples stand out. One involves the close and continuing partnership between URHN and the Policy Development Group in **Ukraine**. District multisectoral networks in **Ghana** initiated community meetings between community leaders and members with network task forces composed of national/regional government representatives and NGOs. In **India**, the White Ribbon Alliance's leadership in advocating for and developing safe pregnancy guidelines made the alliance the logical choice of the MOH to lead in implementing the new guidelines.

Decentralization indeed provides many opportunities to create and strengthen public-private partnerships. In **Nepal**, the RN network is assisting the government in IDU and HIV policymaking and in local implementation of related programs. The three district coalitions in **Romania** were so effective in advocacy and social mobilization activities that national MOH officials met with coalition representatives several times in order to draft the policy and criteria for NGO involvement in public health initiatives.

Organizational competence. This review was hampered by limited documentation on the management and financial capabilities of networks. The experiences of networks, however, suggest that certain elements are important: active communication, resources, and leadership.

- Active communication. During standard network-building workshops supported by POLICY, networks established their internal and external communication systems. The most rudimentary system involved a "phone tree" with each member responsible for contacting three other identified members to schedule meetings, provide updates, and share information, among others. The wide availability and affordability of cell phones made communication among members even easier. Small grants from POLICY enabled networks to buy fax machines or computers and subscribe to local servers for email and internet connections.

Modern communication technology has helped networks to achieve several results rapidly, but such communication systems must be used actively. Reports submitted by URHN of **Ukraine** pointed out that even early on when the network had just been formed, members actively exchanged information and experiences during and outside network meetings, thereby helping the new network to “gel.” Moreover, communication flowing between networks and other groups including supportive government officials or agencies as well as other NGOs—as occurred in **Guatemala**, **Peru**, and **Romania**—allowed sharing of challenges as well as updates on government actions. Sharing of presentations, fact sheets, and best advocacy practices fostered coalition building several times and contributed to a number of successful advocacy campaigns in **Guatemala**. Communication between local groups and district networks in **Ghana** enabled the networks to serve as conduits between civil society and the government. In **Peru**, information exchanges among national and local networks with other NGOs and groups, such as mediation centers, facilitated exchanges of best practices and prompt resolution of problems and conflicts.

- Resource mobilization and utilization. The availability of an array of resources from POLICY, particularly small grants and related technical assistance to form advocacy networks and to plan and implement reproductive health advocacy campaigns, have been cited by the networks above as important elements that helped build their organizational and technical capacity as well as achieve advocacy objectives. Fund-raising and management were often included in the project’s training programs for networks—including network building, TOTs (such as those conducted in **Ghana** and **Russia**), advocacy skills building, organizational strategic planning (as in **Turkey**), project proposal development, and small grants management.

Although resource mobilization was often viewed by networks as entailing donor sources, the members themselves are a network’s most valuable resources. The importance of mobilizing resources within the network was demonstrated by members of **Ukraine’s** URHN. URHN members volunteered their own time and personal and organizational resources to design, print, and disseminate the network’s brochure. The initiative arose from network members themselves, cognizant of the need to provide the network with a distinct identity as well as disseminate information about URHN as an advocacy organization at a time when civil society-led advocacy was still a very new concept in the country. The Constanta network in **Romania** also demonstrated willingness on the part of network members to invest their own time and resources to advocate for their latest issue: integration into the European Union and what it means to young Romanians. In both countries, member-funded initiatives reinforced personal as well as organizational commitment to the network.

- Capabilities for resource mobilization and leadership as ingredients for sustainability. Resource mobilization for the network proved valuable in sustaining the district advocacy networks in **Ghana** and the Constanta coalition in **Romania** after POLICY assistance to the networks ended. Using skills in proposal preparation and small grant management, which they attributed mostly to past POLICY training and technical assistance, these networks applied for and won grants from international and in-country donors.

Information from the field indicates that the specific RH networks from these two countries continue undertaking advocacy activities. Resource generation and sharing, coupled with leadership, are essential to sustainability. Concerns about sustainability raise questions about what and why advocacy networks continue to function even if POLICY assistance ends. From observing the Constanta coalition in **Romania**, the author theorizes that the visionary and participatory leadership style of the network coordinator may be one factor contributing to the network’s continued involvement in FP/RH advocacy. Of the three district networks formed in 2001, only the Constanta network continues to exist and undertake advocacy activities. Network

members cited the network coordinator for her efforts to secure funding and foster continued commitment and shared responsibility among members. Romania is only one example, but here we see some of the keys to network sustainability.

Inclusiveness and Representation in Policy Development and Implementation

Inclusiveness and representation in FP/RH, maternal health, and HIV networks. In general, most FP/RH and maternal health networks were multisectoral in composition, drawing organizations and individuals supportive of a broad range of reproductive health concerns. The multisectoral FP/RH alliances in the focus countries almost always included women's groups, family planning service delivery organizations, and health professional or provider associations. These networks advocated for a wide range of FP/RH issues. Data limitations prevented this review from delving more deeply into the extent to which actual network membership represented those most directly affected by the FP/RH issues that were being addressed through advocacy. **Turkey's** KIDOG, for example, was composed of women's groups and family planning associations headed by highly educated, highly connected women professionals working for women's health, education, and legal rights. Clearly, these women are not typical of the women in Turkey or elsewhere. Their connections, however, served the network well in terms of accessing high-level decisionmakers.

In contrast, HIV networks appeared to be more homogeneous in terms of composition. These advocacy groups comprised people living with HIV, high-risk groups, and their family members and supporters (as in **Peru's** two HIV networks). Thus, representation of the most affected groups and individuals is very much the case for HIV-related networks. This is true of **Nepal's** RN network. The IDU sector was not involved in Nepal's policymaking processes at all until the RN network of IDUs was organized and strengthened with various technical and advocacy skills that made it an effective group for representing the sector in policy review, formulation, and implementation.

Two types of networks pose great potential for networking and advocacy initiatives. The first involves local networks. Local networks in **Ghana, Peru, and Romania** included both prominent women's groups and NGOs as well as grassroots organizations, women's neighborhood associations, youth leaders, ethnic or regional organizations, indigenous groups, and community associations. Representation seems more likely as well as feasible for local networks and coalitions, and decentralization initiatives in various countries provide them with various opportunities to influence policymaking and development locally, and through contacts or membership with national coalitions (e.g., **Peru's** RNPM and ForoSalud) may eventually influence national policymaking (as happened in **Romania**).

The second involves sectoral networks. "Sector" is broadly taken here to mean individuals and organizations from the same professional or social grouping, such as the journalists' network in **Peru**. While not the focus of the case studies above, faith-based networks have the potential to be influential sectoral advocacy networks in terms of building support for FP/RH and HIV issues. In many countries, including **Uganda** and **India**, faith-based organizations have formed networks to address FP/RH and HIV in their own religious communities as well as countries. In **Mali**, for example, prior to 2005, there had been no organized, structured, and planned effort by Islamic leaders in the country meet the FP/RH or HIV needs of their communities. As a result of POLICY's technical assistance, the Muslim Supreme Council created two national networks of Islamic leaders (one for FP/RH and one for HIV) and issued policy documents on Islam's position on various related issues. The FP/RH policy document specifies that religious leaders favor birth spacing among couples, using modern contraceptive methods, and

promoting girls' education. In response, Islamic leaders have organized public meetings on FP/RH using a presentation on Islam and family planning produced with POLICY support. The policy document for the National Islamic Network on the Fight Against AIDS outlines the network's vision on care for people living with HIV and guidance on other HIV issues. The network has also adopted a three-year action plan that includes care and support activities.

Representation in networks other than reproductive health-focused alliances. Peru's ForoSalud coalition was formed by various NGOs and people's organizations to represent civil society in the National Health Council. ForoSalud, together with organizational founders, is also forming local ForoSaluds and supporting the newly formed coalitions to represent civil society in local health councils. These new national and local networks have FP/RH backgrounds and, thus, have great potential to represent reproductive health in broader health policy and planning efforts and even in implementation and evaluation. Peru's networks provide a model demonstrating how the membership of FP/RH-supportive groups in broader health coalitions can help neutralize limited support for FP/RH at the national level.

Public Sector Engagement

Garnering support for a policy change initiative by finding and working with a public sector champion proved effective for URHAN in **Uganda**. The policy champion, a high-level official in the MOH's reproductive health unit, was a valuable ally, providing input to the network's advocacy initiatives and policy proposals, as well as promoting adolescent health policy change and URHAN's inclusion on the committee to review and revise the draft policy. In **Turkey**, Dr. Rifat Köse, the head of the General Directorate of Maternal and Child Health/Family Planning of the MOH, proved to be a critical champion as he soon recognized KIDOG's potential in publicly espousing contraceptive security as well as in providing input to the national strategy for women and children's health from a women's group perspective. In **Romania**, multisectoral advocacy coalitions in three districts were so effective in conducting public events and promoting reproductive health issues to local health officials that it was these local officials that brought up the networks and their advocacy issues to national officials. Moreover, the networks' initiative, as well as responsiveness in providing feedback to policymakers on local policy implementation, reinforced their access to the decisionmaking arena. Two high-level MOH officials (the directors of the reproductive health directorate and the budget) soon recognized what the coalitions could do, and became champions of the coalitions and their contraceptive security issues.

Sustainability of Advocacy Initiatives

The country case studies illustrate that particular factors that made networks effective also played key roles in sustaining advocacy initiatives even after POLICY assistance ended. These factors include a shared goal or objective, inclusiveness and public sector engagement, and technical as well as organizational competence. The White Ribbon Alliance in **India**—supported by its broad and widely inclusive membership—continues to work with the government to help ensure implementation of maternal and child health policies and programs. The ability of the Constanta network of **Romania** to actively engage the public sector, due in part to the network's leadership and organizational skills, underlies why this district network continues to advocate, even today, for a wide range of development issues. District advocacy networks in **Ghana** remained active even after POLICY's country program ended. This was because many network members—local government officials, NGOs, provider groups—were also FP/RH program implementers. Network members ably raised funds or leveraged resources from donors, the government, and community groups to advocate for salient local issues such as prevention of adolescent pregnancy and

HIV. Leaders from implementing agencies are also making use of the Repositioning FP Initiative to advocate for the integration of FP into HIV and environmental programs.

Although the foregoing case studies illustrate that civil society-led networks and coalitions can play a significant role in building political and popular support in policy processes, a major criticism of civil society advocacy is that it often disappears when donor or project support ends. The KIDOG network in **Turkey**, for instance, became inactive after POLICY assistance ended. The same is true of the ABLE network in Pangasinan Province in the **Philippines**. But by the time they ceased to function, these networks had contributed to significant policy changes, demonstrating how advocacy and public-private partnership can promote contraceptive self-reliance. Furthermore, some networks and coalitions are meant to be temporary alliances in response to an urgent issue or challenge. In **Guatemala**, a series of coalitions were formed to address specific FP/RH challenges that emerged over the years. The same two or three women's groups were often part of these coalitions, along with different NGOs, and these alliances ended as soon as positive government action occurred.

Thus, while some civil society-led networks disbanded when project support ended, evidence shows that many individuals and member organizations trained on advocacy under POLICY continue to use their skills and achieve results. The sustainability of advocacy efforts can actually take several forms. Individual champions from networks in **Ghana** have given fresh perspectives to district-level advocacy and are helping to promote FP-HIV integration at the program and service delivery levels. Individual as well as organizational members of the national RH advocacy network in **Ukraine** have advanced advocacy for a range of RH issues at the oblast or city level. Local citizen surveillance committees continue to monitor patients' rights in **Peru**, even emerging as models for citizen participation. Clearly, decentralization provides opportunities to sustain advocacy for policy reform at the decentralized or implementation level in order to ensure that policies are translated into action and results. Civil society advocacy groups such as those in **Romania** have also focused on other advocacy issues by using skills they learned in the FP/RH arena. In **Peru**, as well as in other countries, advocacy networks and groups that were trained by POLICY have also become members of other health or development coalitions, in turn widening the potential application of advocacy skills learned under the project.

CONCLUSIONS

The country case studies presented support the body of evidence emphasized in various reports by coalition and partnership experts, advocacy groups, and donors regarding the factors that resulted in effective networks. Overall, national or local networks and coalitions that directly influenced policy reform were able to do so because they were well organized, committed, unified around a shared goal or objective, focused on their chosen advocacy issue, equipped with the requisite technical skills, and allied with various groups. Once government champions and supportive groups are identified, networks must partner with these champions and groups to maximize effectiveness. In numerous countries where the foregoing occurred, civil society-led networks have truly helped to reshape policy environments. Network advocacy for FP/RH or related issues continues in some of these countries; in other countries, member organizations or individual champions from these networks carry on advocacy efforts for FP/RH or related issues.

The POLICY case studies provide a deeper understanding of how these various factors played out in different country contexts. Often, these factors were interrelated or contingent upon each other: commitment to a shared goal or a defined issue motivated organizations and networks to work together; a shared goal or issue led to reaching out to other groups and even public sector champions; a goal widely shared by various groups drew the attention of decisionmakers.

The case studies showed the breadth and extent of what networks can and have achieved in various countries. They also provide coalition-building and advocacy models for policy change and implementation not just for FP/RH, maternal health, and HIV issues, but even for other social development concerns. For example, district-level networks in **Africa** are consolidating local organizations and groups and working closely with government agencies and NGOs to address myriad problems together. Eastern European countries provide successful models of network building and advocacy despite their limited history of civil society participation in policymaking. **Ukraine** provides a model where a national NGO-led network, in close partnership with a government-led policy development group, can support local reproductive health advocacy and policymaking. **Romania** presents a bottom-to-top model where district-level coalitions galvanized local groups to influence local officials who, in turn, influenced national policy change.

In several countries, especially those that are decentralizing, regional/district networks may be more effective because of their potential for “educating” grassroots groups in participatory advocacy and policymaking, as well as in leading or monitoring policy implementation. The actions and accomplishments of various networks and coalitions in **Peru** and **Guatemala** allude to their organizational maturity, their pronounced influence on reproductive health policy development and implementation, and the potential of civil society networks to become active agents of democracy and governance, ensuring people’s participation as well as responsiveness and accountability from public officials.

The case studies also suggest that most of these factors have played key roles in the continuing of network advocacy activities even after POLICY assistance ended. Because networks and coalitions are composed of organizations and individuals from various sectors and they can be most effective and more likely to be sustainable if they continue working together, the term “networking” perhaps is more apt than “network” because it reflects the ongoing and evolving nature of their involvement.²¹

²¹ This is an idea advanced by Danielle Grant, POLICY Project.

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